

# WORKING TOGETHER!?

## The Anglican Response to HIV & AIDS in Africa



**Anglican United Nations Office Geneva**

in partnership with  
**CAPA HIV&AIDS Programme**



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**Suggested Reference:**

Anglican UN Office Geneva, “WORKING TOGETHER!<sup>1?</sup> – The Anglican Response to HIV&AIDS in Africa”, report to WHO and UNAIDS, (AUNO Geneva, November 2007)

*Photographs used with permission*

## Acknowledgements

This study was carried out by the Anglican UN Office Geneva, working in partnership with CAPA HIV&AIDS, TB and Malaria Network. Field work and preparation of an initial report was carried out by the consultant, Dr. Sheila Bharathan, in liaison with CAPA staff led by Mr Emmanuel Olatunji. The final report was prepared by Revd. Michael French (AUNO Geneva) who also directed the project. The work was partly funded by grants from WHO & UNAIDS.

Thanks are also due to Ruth Foley, Revd. Paul Holley, Revd. David Peck, Ted Karpf (WHO) and Sally Smith (UNAIDS). We also acknowledge with deep respect the countless people within the worldwide Anglican community who have responded with commitment and integrity to working alongside those of all creeds and backgrounds in responding to this challenge, and above all, those who find themselves living with HIV and do so with great dignity and courage.

### Anglican UN Office Geneva (AUNO Geneva) ...

... has emerged in recent years as an interface between the Anglican Communion and Geneva-based institutions related to the UN. AUNO Geneva supports the work of the Anglican UN Observer in New York. It is currently staffed on a largely voluntary basis, involving Anglican clergy and lay people with an extensive background in international issues.

AUNO Geneva has undertaken this study at the request of UNAIDS and WHO. Other Christian traditions and faith communities have also been doing similar work. AUNO Geneva represents Anglicans and therefore speaks out of an Anglican context. At the same time it works on the doorstep of institutions for which faith communities may possibly appear to be curious beasts. It is clear that interpreting each to the other is a necessary task.

### Council of Anglican Provinces of Africa (CAPA) ...

... is an Anglican regional organization that was established in 1979. Its goal is to coordinate and articulate issues affecting the Church and communities across the continent. The CAPA HIV&AIDS Programme aims to strengthen the collective HIV and AIDS response of Provinces and Dioceses.

Following CAPA's latest meeting in October 2007, the media (Church Times, 12<sup>th</sup> Oct) reported under the headline 'AIDS heads African agenda', indicating the continuing priority CAPA gives to addressing the challenge of HIV.

## Introduction

This report is addressed *firstly* to the international institutions – among them WHO and UNAIDS – to give an account of the extent and nature of the Anglican response to HIV and AIDS, and to foster an appreciation of Anglicans as effective and credible partners.

*Secondly*, it speaks to Anglicans themselves. It provides evidence of a coordinated institutional effort which can help in building Anglican identity and capacity in responding to HIV and AIDS. It affirms the remarkable work which is already being done, but in particular asks questions about whether that effort needs to be more obviously coordinated: what are the challenges to be faced if Anglicans wish to be taken increasingly seriously *as Anglicans* in terms of partnerships with major global bodies? This may have implications for the continued resourcing of Anglican health service delivery.

The title *Working Together*<sup>!?</sup> is therefore both an affirmation [!] and a question [?]

- Affirmation - in that it is clear that Anglicans *do* work together as partners with a whole range of actors in a multitude of diverse networks and contexts, and this report illustrates that;
- Question - because this study asks: Do Anglicans work in a sufficiently coherent way *with one another* (structurally, institutionally) to make it possible for big global institutions to get to grips with the Anglican Communion as a whole and therefore work with it in partnership?

Now is a significant moment to be asking this question. Increasingly, faith-based organizations (FBOs) are recognized as important partners in health service delivery, as a recent report<sup>1</sup> has highlighted. In a busy world, it is those which structure and present themselves with clarity at the global level which will benefit from these partnership opportunities.

Building institutional capacity to respond to HIV and AIDS is vital. Anglicans recognize this: on World AIDS Day 2006, the Archbishop of Canterbury – head of the worldwide Anglican Communion – drew attention to the Church’s commitment to responding to the pandemic, explaining that ‘Anglicans are working hard to develop further our organizational capacity so that effective projects can be identified and funded.’<sup>2</sup>

This report offers a picture of the Anglican response and an assessment of what the Communion has to offer. Its scope is limited to Africa, and within that continent we have been asked to focus in on three countries: Kenya, Tanzania and Zambia. These have been chosen not by the Anglican Church, but by WHO & UNAIDS, and as such they provide a fascinating sample which draws out some of the many strengths of the Anglican response, as well as the lessons to be learnt.

<sup>1</sup> African Religious Health Assets Programme, “Appreciating Assets: The Contribution of Religion to Universal Access in Africa”, report for the WHO (Cape Town: ARHAP, Oct 2006)

<sup>2</sup> <http://www.anglicancommunion.org/acns/articles/42/00/acns4222.cfm>

## **Executive Summary**

For a brief understanding of the content of this report, the reader is referred to this Executive Summary, supplemented by the Introduction, Recommendations, and country ‘Headlines’ pages.

- This report gives an account of the Anglican response to HIV & AIDS addressed to global institutions, to the international community in general, and to Anglicans themselves.
- It illustrates and affirms the good work being done, and demonstrates that Anglicans provide a remarkable range of grassroots services, making them effective actors whose strengths are already recognized by partnerships of all sorts: government, NGOs, other faith-based, secular entities and so on. Any attempt to engage with the Anglican Communion must therefore take such other actors seriously and include them in dialogue, and the parts of this report on how Anglicans are ‘Working Together with Partners’ in each profile country are intended to point readers to the importance of those coalitions and relationships.
- These show that Anglicans already have significant capacity as credible and effective partners, and that their current work merits greater attention and resources.
- Anglican efforts have been increasingly coordinated since 2001 and institutional capacity is growing. In Africa, the task of facilitating this is in the hands of the HIV&AIDS programme of the Council of Anglican Provinces of Africa (CAPA). The Anglican UN Office in Geneva aims to contribute to strengthening capacity through building relationships with the global institutions.
- Anglican history and polity mean that the energy and ownership of Anglican AIDS initiatives tends to be decentralized and focused at the local level, or at the intermediate level of the diocese. ‘Anglican’ work is carried out through a huge range of networks, partnerships and collaborations, involving international NGOs, other Christian denominations and faith traditions, government, international organizations and so on. There is no one global access point or chain of command. This report tries to help outsiders understand how these Anglican structures work, and how to engage with the Anglican Church on AIDS.
- Attention is increasingly being focused on the need for a more obviously coordinated Anglican response, and senior leadership is pointing the way. The many and diverse Anglican initiatives in the area of HIV are coming together as Anglican capacity grows.
- Current Anglican strengths lend themselves to existing patterns of funding through networks and coalitions and could continue thus. This study reveals that Anglicans have received Global Fund grants as sub-recipients, with funds channelled through other primary recipients. This tends to emphasize Anglican

strengths at grassroots delivery, but does not necessarily enhance institutional capacity.

- However, if Anglicans also aspire to benefit *fully* from the current opportunities for partnership at a global level, and to access funding for which faith-based organizations (FBOs) are seen as likely recipients, then they will want to invest in a more accessible central capacity, structure and presence, and build the necessary relationships with those institutions.
- Anglican approaches are described and some stereotypical impressions of the ‘faith-based response’ are addressed, clarifying that: Anglicans work on an interdenominational and even inter-faith basis; Anglican work is for the benefit of all in the community, not just church members; they do not use their health work as a means to proselytize; they support the use of condoms; they do emphasize abstinence and fidelity, but not in isolation from other pragmatic approaches; their general approach to sexual debates is not narrowly conservative, but realistic about the challenges, whilst consistent with the African context.
- An account is given of the Anglican response in three countries (Kenya, Tanzania, Zambia) which this study has focused on. As a sample chosen not by Anglicans but by WHO and UNAIDS, these give an honest but positive picture, each illustrating different aspects of Anglican engagement, structures and capacity.
- Anglican institutional capacity should increase in the coming years, and it is part of the task of this report to help further that process, whilst highlighting the strengths of the Anglican response to the challenge of HIV and AIDS and commending the Anglican Communion to others as a credible and effective partner.

## **Recommendations**

### **To International Organizations:**

- *Continue to partner with Anglicans through coalitions and networks as at present* recognising Anglicans as credible and effective partners who merit greater attention and resources.
- *Aim to partner with Anglicans in their own right* as part of encouraging growing institutional capacity.
- *Do so by supporting best practice initiatives which can serve as models for replication:* Partner with Anglicans where Anglican structures are most effective and delivery is already strong in order to secure successful outcomes which will build mutual confidence.
- *See partnership as a dual process of both supporting service delivery and also enhancing institutional capacity by programmes which call for and deliver best practice:* Anglicans have significant capacity and are committed to building it. This is best done *in the course of* delivering services (learning by doing) rather than waiting until everything everywhere is finely honed in terms of institutional capacity.
- *Engage with the Anglican Communion:* when engaging, understand Anglican polity as described in this report. Approaches naturally take place through senior leadership, but Anglican polity means that it is also appropriate to connect to various Anglican actors (and sometimes other partners) and engage them in dialogue and collaboration. The various Anglican offices in Appendix 3 can give advice on pragmatism and protocol.
- *Enable FBOs to build their identity around HIV and AIDS by facilitating, funding and enabling mapping, research and building a 'knowledge bank':* the Anglican experience is a good example of the fact that this is lacking and clearly needed. Churches prioritize 'getting-on-with-it', addressing needs at the grassroots, rather than having the means to count and classify what they do extensively. If they are to do this necessary work they require support.

### **To the Anglican Communion:**

- *Invest in partnership with international bodies:* those organizations which engage successfully with international institutions, and reap the benefits in terms of access and improved programmes, do so by committing resources and staff to ensuring that lines of communication and dialogue are open.
- *Pursue a short to mid-term goal of obtaining Global Fund finance as Anglicans:* Anglicans currently receive Global Fund money for HIV and AIDS work through other parties; this emphasizes grassroots delivery but neglects

institutional capacity. The Anglican Church should aim to secure such funding in its own right through an application at country level where Anglican delivery and Anglican institutional capacity is strongest, (possibly accompanied by an experienced NGO partner that can provide credibility and quality assurance). The application will in itself be a significant capacity-building exercise. It should be seen as a pilot, intended to give Anglicans the best opportunity of success and therefore should not be over-ambitious; but it may include plans to extend the model to neighbouring provinces/countries in the chosen region. In due course, the lessons learnt in such a pilot would become a template for similar applications and engagement elsewhere in the Communion.

- *Build an increased sense of Anglican identity around the response to HIV and AIDS:* Anglicans need to know more about exactly what they are doing in the field of AIDS so that they can tell others. The gradual building of a knowledge bank, with an overview of the nature and extent of Anglican work and a means of fostering increased communication between Anglican practitioners would be a practical resource.
- *Make a choice:* Anglicans can continue with a decentralized model, drawing its energy from the grassroots and with funding driven by local (diocesan) level priorities; in this case they will continue to emphasize service delivery and receive resources either from traditional funding relationships, or from global institutional sources as sub-recipients or as a part of coalitions. This may leave them vulnerable in a changing funding climate. Meanwhile, other denominations and non-Christian faith communities are investing in central capacity. It is those who structure and present themselves with clarity at the global level who will benefit from new partnership opportunities with international institutions.
- *But continue to work ecumenically and in coalitions:* there is no benefit in pursuing only narrow ‘Anglican’ interests because experience has shown that to work collaboratively with others is better. There would be sensitivities in appearing to neglect existing umbrella structures, therefore Anglicans should negotiate to find what flexibility there is within these, and pursue a dual strategy of building their own capacity whilst continuing to play a full part in other networks. Partnerships are a guarantor of quality, accountability, transparency and effectiveness.

## Chapter 1: Anglicans and HIV & AIDS in Africa

*"If the international community is to fulfil its commitments to reversing the spread of HIV and treating those with AIDS, then the Anglican Church will continue to extend itself to meet this challenge as an integral part of it."*

Most Revd. Dr. Rowan Williams, Archbishop of Canterbury, 2006

### 1.1 ANGLICAN ENGAGEMENT, DIVERSITY AND POLITY

The Anglican response to HIV & AIDS draws on deep roots in the Church's historical commitment to healthcare, to education and to well-being in the fullest sense. The Anglican churches were some of the first in Africa to rise to the challenge of HIV. There are many examples of excellent work being carried out at the grassroots, all drawing strength, commitment and identity from their roots in the worldwide Anglican community.

#### The Anglican Communion

The Anglican Communion of Churches, with some 78 million members, is the third largest Christian denomination in the world. The Communion has a world wide reach and is spread over 38 provinces in 139 countries. Each member Church, or Province, of the Anglican Communion is governed independently, led by an Archbishop or 'Primate'. Provinces (which usually correspond to national boundaries, though sometimes cover more than one country) are subdivided into dioceses (corresponding roughly to political districts) which are the fundamental units of church administration and governance. Individual churches - also known as parishes - are subdivisions of the diocese. They may cover a neighbourhood, village or several communities and are in effect deeply-rooted Community-Based Organizations (CBOs). There is no central governance of the Anglican Church, which operates as a family of autonomous member Churches held together by a shared history and 'bonds of affection' focused around their recognition of the headship (as *primus inter pares*) of the Archbishop of Canterbury, who since 2003 is the Most Revd. Dr. Rowan Williams.

In some parts of the world, the Anglican Church is called the 'Episcopal Church' (see glossary)

*In this report, aware of the primary audience, an effort has been made to prefer secular or political terms. For example, where Anglicans speak of the 'Province', being an Anglican Church covering one or more countries, we have referred instead to the 'national' Church to avoid confusion with the Province as a political or administrative unit within a country. See the Glossary for further explanation of these terms.*

This study has highlighted the fact that a hallmark of the Anglican tradition is diversity, and this flavours its response to HIV. There is also a tendency towards decentralization of energy and the ownership of initiatives: at a global level it is organized as a family of churches rather than as one hierarchical institution. At a national level, even though there are clear lines of authority through senior leadership, which is duly respected, like any organization based essentially on voluntary association it is necessary always to

engage the grassroots. Therefore the dynamics of Anglican polity and governance structures mean that, when it comes to building a response in an area such as healthcare, energy and ownership tend to be focused at the local level, or at the intermediate level of the diocese (see box – the fundamental unit of church administration and governance).

What this means to the outsider, used perhaps to a more centralized institutional approach, is that the Anglican Communion is not a simple hierarchy, with a centralized chain of command. This can be confusing: the question arises “Who is responsible for Anglican HIV and AIDS work?” The answer is that there is (currently) no one central coordinating mechanism at a global level. Instead ‘Anglican’ work is carried out through a huge range of networks, partnerships and collaborations, involving international NGOs, other Christian denominations and faith traditions, government, international organizations and so on.

Attention is increasingly being focused on the need for a more obviously coordinated response, and senior leadership is pointing the way. The many and diverse Anglican initiatives in the area of HIV are coming together as Anglican capacity grows and more effective structures allow for a more coordinated response. At an African level, the CAPA HIV&AIDS Programme aims to do precisely that.

Rather than diversity and decentralization being a constraint on the Anglican engagement with HIV, this document suggests the opposite: it is these unique features of the Communion which prompt a flowering of initiatives and a creative response – one which is far more effective because it draws its energy from the grassroots, from the faith and committed application of Christian principles by individuals and church communities around the world. These demonstrate that Anglicans already have significant capacity as credible and effective partners, and that their current work merits greater attention and resources.

Here is an account of one such initiative that works on an interfaith basis:

### Salaam Aleikum! (*Tanzania*)

Eight o'clock at night two vehicles bump their way through dense vegetation and came to a halt in pitch black darkness. There is no sign of human occupation other than a small stone structure with a cross on its sloping roof. This is St. Alban's – a small village parish 60 km away from the Diocesan office in Korogwe. The pastor nimbly jumps out of the vehicle with a shout and in the headlights we gradually make out the small forms huddled for warmth at the base of the church.

There are around 70 children ranging from 3 to 15 years brought together by one common factor - called AIDS - which has taken away either their Mums or Dads or both. The parish (by all standards poverty stricken) reaches out to these children and tries to care for and support them in their education and health needs. Individual parishioners take care of school fees. The children live in nearby villages with their grandparents or relatives and attend school.

Whenever there is a problem in the home the parishioners house the children and look after them. Church volunteers constantly visit the homes to check that the children are doing all right. They transport them to the hospitals when they are sick as their relatives are often too busy with their work and their own families. The children meet twice a week in the church in the evenings and during the weekends and interact with the pastor and volunteers. They talk about their studies and problems at home and also learn songs and listen to stories. There are 72 of them and all try to attend the group meetings. The children are from different denominations and religions: 18 of them are Muslims. The church does not differentiate one from the other.

Where do they get the funding? There is no agency or donor. The parishioners themselves raise the money and the Diocesan office sometimes gives them a certain amount. Why do they do it? We learn from the church and its pastor that we need to care for those in need. The pastor himself supports four children on his meagre income! A chilly wind blows and we can see the children shivering. We say *Asante sana!* The pastor says *Salaam Aleikum!* They chorus *Salaam Aleikum*. We leave them feeling humbled and awed.

However, there are some pressing challenges in the face of a changing environment for the resourcing of faith-based healthcare. Because of the way Anglicans work, their responses are not always as visible as they might be, or as coordinated as they may need to be. For example, they may be the major deliverer of a particular service, but funding may be channelled through some other partner. This is in some ways normal and commendable, but it can also result in a less-than-obvious sense of Anglican identity around issues such as HIV and AIDS. It may also make those initiatives vulnerable unless reinforced by a greater collective Anglican institutional capacity.

The task for the international community therefore, in engaging with the Anglican Church and its response to AIDS, is to understand it: that it is not a hierarchy whereby connecting to the top in any one place one automatically engages and mobilizes the whole; instead, one has to connect to various Anglican actors (and sometimes other partners) and engage them in dialogue and collaboration. This document attempts to give some signposts, pointing towards the 'way in' to those networks and therefore the entry points for international institutions and others to engage with the Communion on HIV and AIDS.

The challenge for the Anglican Communion is that to expect this of the international institutions may be unreasonable, and that other faith-based organizations (FBOs) make the task easier by means of a coordinated response at global level. Increasingly FBOs are being recognized as important partners in health service delivery. It is those which structure and present themselves with clarity at the global level which will benefit from this opportunity.

## **1.2 A COORDINATED RESPONSE TO HIV & AIDS**

Despite the strengths of diversity and local autonomy, serious attention has of course also been given to the necessary task of coordinating the Anglican response. This section explains some of the waypoints and structures which have emerged in an African (and global) context. Excerpts from some of the major statements which have arisen out of these events help to give a flavour of the principles underlying Anglican engagement.

*"We, the Anglican Communion across Africa, pledge ourselves to the promise that future generations will be born and live in a world free from HIV and AIDS."*

Vision Statement of the Anglican Communion, Boksburg, 2001

### ***All Africa Anglican Conference on HIV & AIDS, Boksburg, South Africa, 2001***

The All Africa Anglican Conference on HIV and AIDS in August 2001 included representatives from 12 African Anglican provinces and more than 33 African nations, and leadership from the worldwide Anglican Communion, together with donors and observers from international non-governmental organizations and pharmaceutical companies. The Archbishop of Cape Town was given a mandate to develop a communion-wide understanding of the scope of the AIDS pandemic in Africa.

The conference saw the presentation of a strategic planning process to combat HIV that could be adapted and used at provincial, diocesan or parish level. The process focussed on six areas of concern: prevention, care, pastoral care, counselling, leadership, and death and dying. Every province in Africa now uses the ensuing vision statement and the six building blocks<sup>1</sup> as their guiding principles for HIV and AIDS work (see text box).

### ***AIDS Commission of the Council of Anglican Provinces of Africa (CAPA)***

In December 2001, in response to the call from Boksburg, the AIDS Commission of CAPA (led by the Archbishop of Cape Town) was mandated to implement the strategic planning process across Africa. CAPA is an Anglican regional organization that was established in 1979. Its goal is to coordinate and articulate issues affecting the Church and communities across the region.

The Council operates in 12 Anglican provinces in 25 African countries. These provinces are Burundi, Central Africa (Botswana, Malawi, Zambia and Zimbabwe), Congo, the

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<sup>1</sup> <http://www.oikoumene.org/en/resources/documents/other-ecumenical-bodies/church-statements-on-hiv-aids/anglican-communion-africa.html>

**Commitments arising out of the Boksburg Conference, 2001**

6 building blocks arose as guiding principles out of the Boksburg Conference: prevention, pastoral care, counselling, care, death and dying, and leadership. The conference outcome statement addressed these by making the following commitments, entitled 'Our Response'

**Prevention**

Out of love for our children, one another and our communities, we commit to speak openly and with moral authority about responsible sexual behaviour, and to support one another, embracing and adopting behaviours that avoid the transmission of HIV.

**Pastoral Care**

As the embodiment of the merciful Christ in a suffering world, we commit to equip our clergy and laity to support all people, especially those living with HIV, in life-sustaining relationships with their God and their community.

**Counselling**

We commit to promote voluntary counselling and testing for HIV by our own examples and as a ministry of the Church. We call for the establishment of support groups and other counselling services for those who are orphaned, ill, afraid, dying or bereaved.

**HIV Care**

We commit to being central to networks of community support, to meet the health care and basic needs of those who are orphaned, ill or excluded due to HIV, freeing them to productive life as long as their health permits.

**Death and Dying**

As death transforms the body, AIDS calls us to transform those traditions and practices, by which we care for the dying and honour our dead, and which consume scarce resources and contribute to denial.

We commit to: training the Church to provide holistic care for the dying and prepare families for living on; offering rituals that honour the dead and promote the well-being of those who survive; training the clergy to counsel and protect the rights of those who survive, especially women and children.

**Leadership**

Silence permits inaction and is the breeding ground of stigma. We call for bold, compassionate community and institutional leadership at every level, to prevent infection and care for the ill and dying. We invite similar leadership by government, and all sections of society and international partners.

Because leadership must address power, culture and morality, we call on our government leaders to be accountable for health expenditures and to declare an 'HIV state of emergency', in order to combat AIDS and mobilize resources. We further declare that all people have the right to health, which includes access to basic health care.

Indian Ocean, Kenya, Nigeria, Rwanda, Southern Africa (Angola, Lesotho, Mozambique, Namibia, South Africa and Swaziland), Sudan, Tanzania, Uganda and West Africa (Ghana, Cameroon, Togo and Sierra Leone). The Diocese of Egypt is also included.

Out of this process, the CAPA HIV and AIDS Board was established to lead the African response at an institutional level. Most provinces commenced effective implementation of the strategic planning framework in 2002 by recruiting their respective programme personnel and establishing structures in line with the aims and objectives of the framework.

***Statement from the Primates of the Anglican Communion, April 2002***

Upon receiving a report from the Council of Anglican Provinces of Africa (CAPA) on the impact of HIV and AIDS, the Primates of the Anglican Communion who were gathered at Canterbury issued a statement<sup>1</sup> reaffirming the Anglican commitment at a *global* level, including the comment that

- *We are committed to developing a global response to the AIDS pandemic.*

***Statement from CAPA HIV and AIDS Board, August 2002***

In August 2002 the Board recommitted itself to a vision of a generation without AIDS and issued a statement<sup>2</sup> which included specific comment on:

- *An acknowledgment that knowing one's status is crucial, and;*
- *A commitment to make churches 'AIDS friendly' where people living with the virus can experience love, acceptance and hope.*

***Pastoral Letter from the Primates of the Anglican Communion, May 2003***

The Primates of the Anglican Communion issued a pastoral letter<sup>3</sup> to be distributed and read at public worship. The letter included the following:

- *We are determined to engage more deeply in challenging cultures and traditions which stifle the humanity of women and deprive them of equal rights... our greatest challenge is to nurture and equip our children to protect themselves from HIV ... AIDS is not a punishment from God.*

***Boksburg TEAM (Towards Effective Anglican Mission) Conference, March 2007***

In March 2007 Anglican Church leaders met again at Boksburg to assess progress since the first rallying call in 2001, and to determine future directions. In the final statement<sup>4</sup> they remarked that:

- *In terms of our fight against HIV and AIDS, while we acknowledge and give thanks for the present work of the Church, much remains to be done in enhancing our current interventions. In order for the Church to be effective in*

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<sup>1</sup> <http://www.anglicancommunion.org/acns/articles/29/50/acns2961.html>

<sup>2</sup> <http://www.oikoumene.org/en/resources/documents/other-ecumenical-bodies/church-statements-on-hivaids/anglican-provinces-in-africa.html>

<sup>3</sup> <http://www.anglicancommunion.org/acns/articles/34/50/acns3450.html>

<sup>4</sup> <http://www.team2007.org/pdfs/TEAMconcluding%20remarks.pdf>

*caring for people in local communities, we must mobilize both human and economic resources.*

*"As Christian disciples we recognize in God a self-offering in the face of suffering. We are thus compelled to address our responsibility to do what we can to treat the sick and to educate ourselves and others so as to avoid further spread of the infection."*

Most Revd. Dr. Rowan Williams, Archbishop, of Canterbury, December 1<sup>st</sup> 2006

### **1.3 COORDINATION THROUGH CAPA HIV & AIDS PROGRAMME**

The CAPA HIV and AIDS Programme aims to strengthen the collective HIV and AIDS response of provinces and dioceses. Its role is currently a facilitating one. It does not displace national and diocesan mechanisms for managing the HIV and AIDS response. As noted, that response continues to be carried forward by many and diverse actors, funding relationships and networks operating under the governance structures of the Church. Nevertheless, CAPA is the natural and appropriate focus for an identifiably *Anglican* institutional response to HIV and AIDS.

#### **CAPA HIV & AIDS Programme Activities**

- Guide and provide technical assistance to the 12 African Anglican Provinces in the implementation of the African Anglican AIDS initiative, in order to make progress towards their goal that future generations will be born in a world free from AIDS.
- Support and facilitate the development and implementation of Provincial HIV and AIDS plans and response structures, and identify and facilitate access and provide resources to monitor and evaluate HIV and AIDS work.
- Engage in international dialogue on HIV and AIDS, TB and Malaria and establish linkages and networks between Provinces and development partners.

#### ***CAPA Desk Review,<sup>1</sup> Feb, 2007***

CAPA published a 44 page Desk Review of its HIV and AIDS programme from 2001 to 2005 in the 12 provinces, across 25 countries. The study highlights the vision, mission, programme activities, challenges and lessons learnt.

#### ***CAPA Programme Achievements***

At present most provinces have administrative systems in place and have established HIV and AIDS Desks with programme coordinators, and structured and institutionalized programmes in line with the strategic plan. There has been a gradual rise in the number of dioceses which are involved in programme activities. Leadership training and empowerment have been given maximum priority. CAPA now has a pool of experienced professionals as programme coordinators.

<sup>1</sup> <http://hivaids.anglicancommunion.org/resources/docs/CAPA%20Desk%20Review%202001-2005.pdf>

***Integrated HIV & AIDS, Tuberculosis (TB) and Malaria Strategic Plan 2007 - 2011***<sup>1</sup>

The second CAPA HIV and AIDS, TB & Malaria Strategic Plan was launched in February 2007 to scale up CAPA's response in contributing to the global reduction of the three diseases. The plan proceeds from a situational analysis which includes the transmission of HIV, the existence of stigma, denial and discrimination, a review of the health care systems within CAPA, identifying gaps in delivery, the prevalence of harmful socio-cultural beliefs, attitudes and practices, acknowledging vulnerable populations and orphans, and the general HIV and AIDS situation in Africa. The expected outcome of this plan is to strengthen CAPA programme coordination, management and internal institutional capacity, as well as to build new sustainable partnerships to implement the second phase of the CAPA Strategic Plan (2007– 2011).

*"The Church cannot afford to be indifferent because Christ calls us to proclaim his saving love to a broken, fragmented, diseased world - a world in which each of us is directly infected or affected by HIV and AIDS, TB and Malaria."*

Archbishop Peter Akinola, 2007

**1.4 DISCUSSION: AN ANGLICAN HEALTHCARE SYSTEM?**

The strengths of the Anglican response are illustrated throughout this document and the point is made that there is plenty already going on which merits greater attention from the international community, and recognition in the form of resources to redress the balance where faith-based organizations account for between 30% and 70% of the health infrastructure in Africa<sup>2</sup>, but receive a far smaller share of the available funding.

However, in a context where there are increasing opportunities for partnership between FBOs and international institutions, it is clear that an Anglican tendency to organic diversity - fruitful though it may be - may make the job harder for such global organizations. Moves towards a more systematized approach to healthcare would strengthen the Anglican case that it is a valuable partner at an institutional level. Here, we air some of the sensitivities involved and questions which may go through Anglican minds.

There is therefore something of a choice. The current model lends itself to existing patterns of funding through networks and coalitions and could continue thus – a networked, ecumenical, collaborative and decentralized approach may be preferred.

A decentralized patchwork has benefits: it takes seriously the fact that much goes on through partnerships and networks which draw their strength from historical links, institutional and personal relationships which do not take the institutional governance structures of the Church as a *starting* point (although they give them all due respect).

<sup>1</sup> <http://hivaids.anglicancommunion.org/resources/docs/CAPA%20Strategic%20Plan%202007-2011.pdf>

<sup>2</sup> African Religious Health Assets Programme, "Appreciating Assets: The Contribution of Religion to Universal Access in Africa", report for the WHO (Cape Town: ARHAP, Oct 2006)

Some projects and programmes may have good reasons to wish to protect their particular *modus operandi* and since their work has often been built through tenacity and struggle they are cautious about attempts to co-opt them into one over-riding structure. This is all part of Anglican diversity, and such creativity and commitment needs to be fostered without imposing or insisting on uniformity. The case studies given on the following pages are all examples of how grassroots initiative and ownership are crucial.

Decentralization also allows differences to exist and to be held in tension. Diversity – which we highlight as a strength – can also lead to stresses and strains. Many will be aware of media attention given to Anglican differences and debates around areas such as sexuality. Whilst the reality at the grassroots is that many believers and churches get on with ‘business-as-usual’ (responding compassionately to HIV and AIDS for example), these debates nevertheless reflect genuine tensions. A less-defined, less systematized approach allows some elbow room for alliances and relationships to be forged between the like-minded.

However, if Anglicans aspire to benefit fully from the current opportunities for partnership, and to access funding for which FBOs are seen as likely recipients, then they may need to invest in a more accessible central capacity, structure and presence to build the necessary relationships with those institutions and their staff. Others are doing so, and a recent publication makes it clear that “front-end investments by FBOs are required”, which “could include staff time [and] travel,” for example, but for which “a combination of a good track record, technical staff and financial systems are necessary.”<sup>1</sup>

The specifically *Anglican* institutional response is something which is still growing and building. This study raises questions about ‘if’ and ‘how’ energy and ownership of information, funding mechanisms, management etc. can (or should) be more centralized in order to present a united front. Anglican institutional capacity needs to increase in the coming years, and it is part of the task of this report to help further that process, whilst highlighting confidently the excellence of the Anglican response to the challenge of HIV and AIDS.

*“A silence has been broken and a first step is now in place for the Anglican Communion in Africa to make it absolutely clear that we are willing to do all in our power to bring the hope of a generation without AIDS to reality.”*

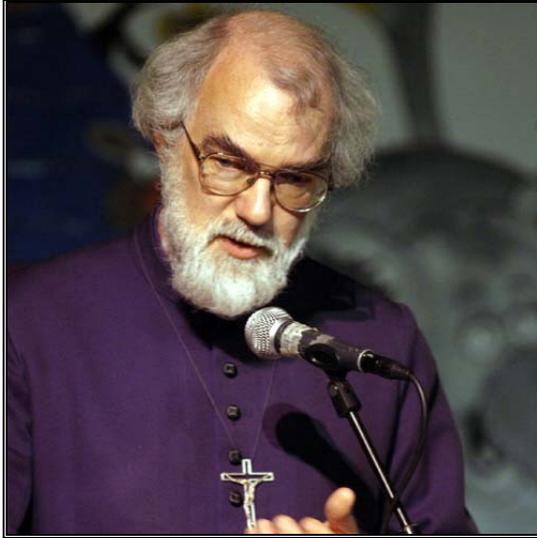
Archbishop Njongonkulu Ndungane, Boksburg, 2001

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<sup>1</sup> ‘Engaging with the Global Fund to Fight AIDS, Tuberculosis and Malaria: A Primer for Faith-Based Organizations’, [http://www.theglobalfund.org/en/files/partners/friends/Manual\\_Final.pdf](http://www.theglobalfund.org/en/files/partners/friends/Manual_Final.pdf)

### FAQs on the Implementation of Anglican HIV & AIDS Programmes

1. Do Anglicans only work with other Anglicans/Christians? **No. Some of our case studies demonstrate that Anglican work is often not only interdenominational but may also be interfaith.**
2. Do Anglicans proselytize through HIV and AIDS work? **No. Anglican health services (and social engagement in general) are not used as a means to proselytize.**
3. Do Anglicans support the use of condoms? **Anglican statements clearly emphasise that all life is sacred and needs to be protected - including by the use of condoms.**
4. Do Anglicans insist on abstinence only teaching? **No. Anglicans believe that sex is a special gift from God and that the values of chastity before, and fidelity after, marriage should be respected. As a community of faith they emphasise these values of responsible behaviour, but their interventions go beyond them to include teaching on effective methods of prevention.**
5. Do the publicized Anglican debates about sexuality reflect a generally conservative or narrow approach to matters like HIV and AIDS? **Again, the various statements issued reflect a realistic approach to the challenges, acknowledging the need for Anglicans to express approaches consistent with the African context.**



*“If the international community is to fulfil its commitments to reversing the spread of HIV and treating those with AIDS, then the Anglican Church will continue to extend itself to meet this challenge as an integral part of it.”*

Most Revd. Dr. Rowan Williams,  
Archbishop of Canterbury, 2006

Most Revd. Benjamin Nzimbi,  
Archbishop of Kenya and Chair of  
the CAPA HIV&AIDS Board, being  
tested for HIV



## **KENYA – THE HEADLINES**

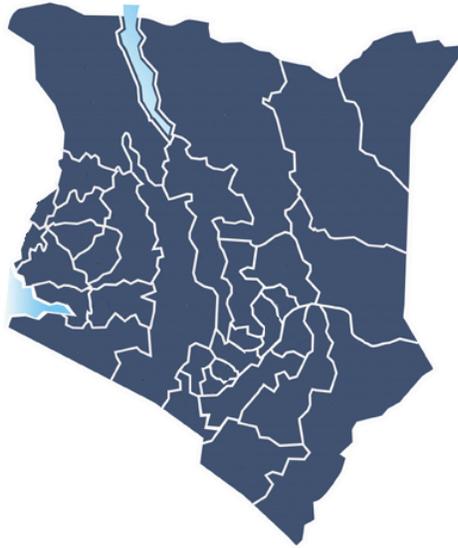
### **Key Features**

- **A Masters degree programme on Community Care and HIV&AIDS has been started at St. Paul’s Theological College, Limuru; clergy and church workers are encouraged to join**
- **All Saints Anglican Cathedral Nairobi runs a Voluntary Counselling and Testing Centre in the cathedral – a sign of institutional openness and commitment to breaking stigma**
- **All bishops and their wives have undertaken a training course including openness about HIV, sexuality, condoms, etc.**
- **Archbishop chairs the CAPA HIV&AIDS board and has led by example by being tested for HIV and publicising this**
- **Strong national coordination of health work through the Christian Community Services (CCS) network**
- **Good working relationship with government and networks of partners**
- **The three Anglican hospitals have Comprehensive Care Centres, including Antiretroviral treatment (with CD4); these are backed up by 86 health centres**

### **Key Lessons**

- **Existing funding patterns don’t heighten Anglican identity around the response to HIV; Anglicans are sometimes ‘hidden partners’. A study of the percolation of major donor funding to grassroot structures may help to assess the contribution of the Anglican Church of Kenya to the overall HIV and AIDS response in the country**
- **Networks of partnerships provide checks and balances to ensure effectiveness, coordination, accountability**
- **Leadership from the top is vital**
- **Inclusiveness is a key message of the Church; this may surprise some of those coming from a non-faith based context, where stereotypes of faith communities sometimes exist**

## Chapter 2: Kenya



Map from <http://www.ackkenya.org/main.htm>

*... insert map of Kenya with dioceses and projects focused on*

### **2.1 THE ANGLICAN RESPONSE AT NATIONAL LEVEL**

The Anglican Church of Kenya (ACK) launched its HIV and AIDS response at the national level in 1997 to coordinate activities throughout the country. The national office of ACK also houses the Department for Social Services (DSS) and the office of the national HIV and AIDS programme and its coordinator. All social action and development programmes at the grassroots are channelled via the nine Christian Community Services covering all of Kenya. HIV has been integrated into these development programmes for ease of implementation.

CAPA is also located in Nairobi and works closely with the DSS. Through this working relationship CAPA ensures that its strategic plan is implemented through the national mechanisms in place. This interrelatedness between CAPA and ACK ensures uniformity of programmes and unity in purpose.

The Christian Community Services manages all the development and social work activities of the Church. Much of their work is done through village health committees with the aim of enabling communities to take charge of their own health. The HIV and AIDS programme addresses all issues relating to the pandemic in 3 programmatic areas,

namely: capacity building, prevention, and care and support. All the 29 dioceses implement HIV and AIDS activities through various departments such as Youth, the Mothers' Union and the Kenya Anglican Men's Association (KAMA).

### ***2.1.1 The Response at National Level – Major Features***

- Track record: The Anglican Church began its social work in the spheres of education and health way back in 1844 by opening schools and hospitals.
- Treatment Facilities: To-date ACK has 86 health facilities and three main hospitals, all of which run HIV and AIDS activities including antiretroviral therapy (with CD4 facilities).
- The 34 Bishops and their wives were given a one week training in 2003, which included education on sexuality and condoms.
- A Master's degree programme on Community Care and HIV and AIDS has been started at the St. Paul Theological College, Limuru, and ACK has encouraged clergy and church workers to join the course.
- 54 Diocesan coordinators have been trained. Diocesan HIV and AIDS programmes are being implemented in all 29 dioceses.
- 54 counsellors have been trained as well as 54 trainers-of-trainers in leadership and programme management.
- Church groups such as Sunday Schools and Brigades, Youth Groups, KAMA and Mothers' Unions have been trained in HIV and AIDS prevention and care.
- A needs assessment survey was undertaken in 2004 in each diocese and was incorporated in the 2004 – 2008 national strategic plan.
- A national youth outreach programme, in partnership with Family Health International, has trained peer educators, HIV and AIDS committees, focal persons and puppeteers.
- Anglican clergy and church workers are beginning to share their experience of living with HIV. The week preceding December 1st each year is assigned for HIV and AIDS activities in the parishes. During this week Anglican leaders speak openly and publicly on HIV and AIDS concerns.
- Policy Formulation: when the Kenyan Government's national HIV and AIDS plan was launched, the churches were also invited to the meeting. This was an open acknowledgement that churches are *the* structures that have reach at the grassroots level.
- Leadership involvement: Archbishop Benjamin Nzimbi of the ACK has been the Chairperson for the CAPA AIDS Board. He has been actively involved in national and regional AIDS initiatives. The Bishop has also been openly tested for HIV.
- Programme implementation: Planning is done on an annual basis. As HIV and AIDS is not a stand alone issue, other programme staff are also involved, such as food security, nutrition support, income generation, safe water, etc.
- A nationwide Family Dialogue programme encourages openness and debates between parents and young people to encourage safe practices.

- The Church participates in advocacy in partnership with the Ecumenical AIDS Initiative in Africa (EHAIA), African Network of Religious Leaders Living with HIV&AIDS (ANARELA) and other NGOs.

*(figures as reported by Anglican sources)*

#### **Month of HIV & AIDS Awareness (Kenya)**

The ACK has decided that for one whole month every year all Dioceses and every church will run various activities focussing on HIV concerns. Every group within the church like the Mothers' Union, the Men's Fellowship, the youth, and the Sunday School have special activities like concerts, debates, special sales, fellowship with people living with the virus, and sermons to sensitize and motivate people to become involved in HIV and AIDS concerns. Current and relevant information on HIV issues is conveyed to the Dioceses by the national church office, which in turn is passed on to churches. These activities also involve the local communities. In 2005, June was chosen to be the month of awareness. The programme began with a sermon by the Archbishop at the Cathedral in which he apologized to the world for the Church's earlier attitude of denial, silence and discrimination. This was given national coverage on TV. In 2007, he led members of the ACK in going for VCT with his wife, another event which was televised nation-wide.

#### **2.1.2 Programme Challenges**

There is a rising demand for HIV and AIDS services within church institutions, especially following sensitization. However, stigma is still high and hinders VCT programmes. The sustainability of the Diocesan HIV and AIDS programmes and desks is a major limiting factor. Role modelling for behaviour change both in the church and community still needs to be strengthened. Community structures for the care and support of the infected and affected are not sufficient. Resources remain a major challenge and there is an urgent need to keep motivation high as the church cannot afford to lose the momentum gained.

#### **Anglican Day of Prayer (Kenya)**

In 2007 HIV and AIDS was the theme for the Anglican Day of Prayer. This was communicated to all churches where congregations are sensitized and involved in activities. On the day, these took the form of educational seminars, fasting and praying for HIV and AIDS issues and those affected, giving material support to them and offering other services in kind.

#### **A Hidden Partner! (Kenya)**

This study revealed that ACK hospitals, schools and churches are often the implementing structures for projects and programmes funded through major donors such as USAID, UNICEF and GFATM. They are however sub-recipients and unaware of the source of funding which reaches them through other principal recipients. The funding partners are also unaware that it is ACK that are implementing their programmes at the grassroots and are providing them with data through the principal recipients.

## 2.2 ANGLICAN RESPONSES AT DIOCESAN LEVEL

As explained above, in Kenya all social action and development programmes at the grassroots – including its response to HIV and AIDS - are channelled via nine Christian Community Services (CCS) organizations covering all of Kenya. The various CCS structures do not correspond to single dioceses, but to clusters of dioceses; therefore the ‘diocesan’ level response described here actually relates to those clusters, each covered by a different CCS.

### 2.2.1 *Christian Community Services Western Region (WRCCS)*

The office of the Christian Community Services of the Western province (political, not Anglican) is located in Kakamega and covers the Dioceses of Maseno North, Bungoma, Butere, Katakwa, Mumias and Nambale. It has been functioning since 1997 implementing activities in the 14 districts of the (political) province. The organization’s coverage is divided into four zones based on the climatic and demographic conditions: Eastern Area, Sugar Belt Area, Lake Area and Mountain Area. A total of 55,000 households are targeted in these Areas of operation.

#### *The Response – Major Features*

- Implementation strategies in communities focus on capacity building, human rights, good governance, food security, environmental conservation, economic empowerment and health, among others.
- ‘*Transport Corridor Initiative*’: In the Lake Area there are large numbers of displaced persons, and sex trade along the transport corridor is rampant (see text box).

#### **Transport Corridor Initiative (*Kenya, WRCCS*)**

This programme is implemented in partnership with Family Health International where the truckers are provided with recreational facilities as they await clearance which can last up to one month. Town halls are provided with a large screen television where games can be watched. Other amusements include satellite televisions, pool tables and other games. HIV and AIDS awareness material is made available and VCT services with a trained counsellor are provided. This project in Malaba has been very effective and plans are being made to duplicate this in other areas.

- Other HIV and AIDS prevention and mitigation programmes have a focus on orphans and vulnerable children, carers, and people living with HIV and AIDS.
- ‘*Choose Life*’ Youth AIDS Prevention Programme: The church promotes abstinence programmes especially for those who are in school. 18,000 youth have been trained and the target for the end of 2007 is 27,000. These 27,000 peer educators will in turn reach a total of 93,000 across the community. The youth programme is being undertaken in all 6 dioceses.
- 20 people work for the WRCCS on advocacy, 15 of them being volunteers. They advocate on issues of access to treatment, food security, and OVC. The HIV and AIDS advocacy for the diocese is done in partnership with ecumenical bodies.

- ‘*Maseno Hospital*’ (see text box)

#### Maseno Hospital (*Kenya, WRCCS*)

The 150-bed Maseno hospital offers ARV treatment and has three field projects located in the two Districts of Lugari and Emukaya. The hospital also has facilities for CD4 monitoring. In 2004 the hospital began its programme on PMTCT with assistance from the Catholic Mission Board and the Christian Health Association of Kenya (CHAK). In June 2007 a Comprehensive Care Centre was established with provision for ARV treatment, VCT and PMTCT.

There is a team of 14 persons led by a full time doctor with clinical officers, nurses, data clerks, a pharmacist, and VCT counsellors. Several volunteers serve as adherence counsellors. 1567 HIV positive patients have been enrolled and 625 are on ARV therapy. The doctor sees on average 50 patients a day. Approximately 50 new patients are started on ARV every month. 76% of those who receive ARV are men. Children account for 12% of this number. There are 15 to 20 patients tested daily. They are referred by the community health team as well as by the patients themselves. The mobile unit accounts for a further 15 persons per week.

The hospital coordinates with the community health team for follow up treatment adherence, support group link up, home based and orphan care and income generation activities. There are 22 community nurses who, through the satellite services, reach out to the far flung areas, and around 60 patients are seen and treated every Tuesday at these clinics. People living with the virus serve as volunteers and churches and church structures are used to run the clinics.

The Children's Club of the hospital meets twice a month and addresses the children's needs, especially offering psycho-social support to help them discuss openly the effect on their lives and plan for their future. Meetings are opportunities for children to express themselves and sometimes to get over their anger. Food support is ensured for all members. They are also taught skills like printing T-shirts and are helped by the Diocese in selling them. Children also go on camping trips out of town where they can relax and learn skills.

Maseno hospital partners with other organizations such as CRS and CHAK, AIDS Relief and Mission for Essential Drugs. It receives government funding as well as funds from overseas friends of the hospital.

- PMTCT and STI control programmes have targeted around 200 persons per programme. The Diocese has 4 VCT sites and 120 persons trained in counselling. CCS Training is offered in the areas of prevention education, counselling, advocacy, orphan and home-based care, and staff capacity-building. They are supplied with test kits, home-based care kits from the Government, and depend on other NGOs for IEC material.
- 30 people, 28 of them all volunteers, work on a programme reaching out to 2,400 orphans. 250 widows are supported with food, clothing, and medical care, and provided with housing, goats and handicraft training for income generation. 50 persons living with the virus are being supported with temporary shelter, and are offered day care and medical aid. Funding for both programmes is generated

from within the church and community. The Mothers' Union is the key group involved in orphan and widow support.

- 'Life Wire Shamba': These are agricultural farms which demonstrate the growing of nutritious food for those living with the virus. Those with low income and especially widows are given financial help and seedlings to get them started.
- 'Jikaze' (see text box)

*(figures as reported by Anglican sources)*

**'Jikaze' (Kenya, WRCCS)**

***"The greatest enemy is self stigma - the church helped me overcome it"***  
**(Fanhae Emitunga)**

A dusty track through overgrown bush vegetation leads to the Namsoli Health Centre of the ACK, situated in the District of Kakamega. Established in 1952, this 25-bed health centre, efficiently run by a ten dedicated staff members, caters to a population of 30,000. Since 2004 it has been actively involved in VCT and PMTCT. There are 45 members belonging to the support groups which meet at the centre twice a month, 12 of them on ARV.

'Jikaze' (meaning 'Keep it Up') is an 8-member support group of women who are hosted by the centre. They pay 50 KSh on registration and a monthly subscription of 20 KSh for medical care. The women find support and solace through the group meetings, through visiting each other in their homes and through activities such as raising chickens and tending kitchen gardens. Initially a chicken is donated to each woman. One of them in turn rears them to increase the numbers, while the others use the eggs. The hatched chickens are distributed among the members. The group looks after 45 orphans in their community, and group members visit homes to offer HBC to those in need. Each woman relays a story of hope.

40 year old Fanhae Emitunga is one such woman. She is an active member of the group and attends the Salvation Army Church. She was diagnosed as HIV positive in 2004 and had to travel all the way to Busia at the Ugandan border to have her CD4 test which was found to be 12. Determined not to give up, Fanhae travelled to the hospital in Yala where she managed to get enrolled on the ARV programme. Now, three years later, her CD4 is maintained at 319. She looks after her four children who are all negative. Initially when she was found positive she faced discrimination, especially when her friends stopped visiting her. But the community health worker and the support group at the Namasoli Health centre gave her hope. The church workers visited to pray with her and cheer her up. She continued to visit her friends in spite of the cold shoulder she received. Gradually her friends accepted her again, and now she walks into their homes as before. "Once I was healthy, I knew I was no different from others" she says. "The greatest enemy is self stigma and the church helped me overcome it."

***“The greatest enemy is self stigma -  
the church helped me overcome it”***  
(Fanhae Emitunga)



### ***2.2.2 Pwani Christian Community Services (PCCS)***

Pwani Christian Community Services in Mombasa cover the two Dioceses of Mombasa and Taitaveta on the coast. Its activities are implemented in 5 districts. A survey was carried out by the church in 2004 to determine the numbers of Anglicans who were living with the virus. 6% of Anglicans tested were found to be positive while the national prevalence then was 6.7%. The church, convinced that much work needed to be done, established the HIV and AIDS desk in 2005. There are 4 paid workers and 252 volunteers for the two dioceses. There are 54 parishes, 72 clergy and 50,000 parishioners.

#### ***The Response – Major Features***

- Bishop of Mombasa requested that sermons should be linked to the issue of HIV as much as possible in order to mainstream it.
- ‘*Mwatate Lifeskill Development Project*’, and the ‘*ABY Reach-Out Programme*’ are the two main PCCS projects. These are being implemented in 28 congregations spread throughout the Kilifi, Mombasa, Kwale, Malindi and Taita Taveta districts.

#### ***Friends of the Youth (Kenya, PCCS)***

Friends of the Youth aims to support the difficult-to-reach who generally fall out of the realm of organized youth outreach programmes, such as home carers, school drop outs, drivers and relatives from rural areas staying with urban families. 100 congregations have been targeted and at present there are 37 centres. The trainers are ‘mature’ people who have the confidence to reach out and interact with this group. 56 people have been trained, 2 from each congregation and 1 from the community. The programme is implemented in partnership with Family Health International. The group has also been trained in Home-Based Care using the Kenya Ministry of Health HBC Curriculum prepared by the CRS.

- An ABY programme runs in partnership with Family Health International (FHI). Clergy are initially sensitized and animators are trained as peer educators. 14 congregations went on to sensitize 26,000 members of the community through theatre and skits.
- The Coast Churches HIV and AIDS Initiative (CCHIA) has been formed with 16 congregations, including Anglicans, Methodists and Catholics. Health days are observed in the churches, and health-related education is given during these sessions which are promoted by the Ministry of Health.
- Five people have been trained in counselling, and there is one VCT centre in Mombasa. Mobile VCT services are also offered.
- Training is given in advocacy, prevention education, counselling, home-based and orphan care.
- Around 3000 IEC materials a year, supplied by KANCO, are distributed to church congregations.
- Kaloleni hospital in Mombasa Diocese provides treatment for opportunistic infections as funding is inadequate to run ARV services.
- Hospital staff have conducted trainings for community health workers, all the schools in Kaloleni area and 60 religious leaders from all faiths.
- The Global Fund through the MOH has provided a building for comprehensive care which includes VCT, PMTCT, community outreach and treatment.
- Over the last 2 years, the Kaloleni hospital has tested 403 persons of whom 163 were found positive. There are two support groups linked to the hospital. The ministry of Health provides drugs for the PMTCT programmes where around 50 women have been treated.
- PCCS cares for 80 orphans providing nutrition and medical aid. There 14 persons working on this programme.
- 54 volunteers are being trained in providing support for those living with HIV.
- ‘*Peace and Justice*’ is an advocacy programme in partnership with Christian Aid where 16 persons and 454 volunteers are involved in advocacy efforts.

*(figures as reported by Anglican sources)*

### ***Programme Challenges***

The main challenge is the assumption that churches should work with volunteers as part of their mission. There is also a belief that churches are already well funded by organizations, which is not the case. Every congregation has a group of 10 volunteers led by the pastor to deal with HIV concerns. The volunteers invariably lose motivation and face burn out, resulting in loss of the time and resources invested. The challenges faced by the Kaloleni hospital include the shortage of nurses, and a lack of community mobilization.

### Kilifi Youth Group

The Kilifi Anglican church nestled in a small village in the Pwani Diocese is proud of its youth group who, in coordination with the village youth, reach out to a community with interventions that complement existing services. The youth reach out to their peers and communities with prevention messages, displaying an almost professional talent. Many have volunteered and taken an abstinence pledge. As a group they feel united and strengthened to handle peer pressure. The members of the community who need to enrol for PMTCT or STI control programmes, or who desire to opt for VCT, are transported by the youth on bicycles, and are encouraged and supported during the logistics of registration, follow up and referral. Activities take place after school hours or during the weekends when they can visit homes. Many of them are trained to deliver home-based care to families and orphans. The youth group also includes Catholics and Muslims, and they reach out to all irrespective of religious affiliation. Their commitment stems from the conviction that as young people, they are the group most affected by HIV and AIDS, and that it is their responsibility to reach out to their peers and set an example to the community.

#### **2.2.3 Mount Kenya Christian Community Services**

The Mt. Kenya Christian Community Services serves the Dioceses of Embu, Meru, Mbere and Kirinyaga. The HIV and AIDS programme at the CCS office is coordinated by two paid staff. Individuals living with the virus form a team of volunteers who help with the programme, particularly with home-based care.

#### ***The Response – Major Features***

- Prevention: work among youth, congregations, sex workers and communities.
- VCT sites with 5 trained counsellors and 260 people tested.
- Distribution of 1,000 IEC materials per year to youth groups, to communities, and to people living with HIV.
- Training by CCS in animation, prevention education, pastoral care, counselling, advocacy, care of orphans and palliative and home-based care, income generation, initiating small businesses, poultry farming, agriculture and kitchen gardens.
- ARV therapy is provided through the Mwea Mission Hospital funded by the Ministry of Health.
- Reduction of stigma and support to those living with the virus - medical care, support group activities and income generation activities.
- Support of orphans and other vulnerable children: 550 orphans are supported in the Utugi Children's Home in Kirinyaga, Embu Rescue Centre, and Makutano Children's Home in Mbere through education, medicine and clothing.
- Home-Based Care: 95 families are supported through home-based care by the Global Fund through the Primate's World Relief and Development Fund (Canada).
- Advocacy efforts are undertaken at the level of the CCS on issues surrounding orphans, vulnerable children and the reduction of stigma.

*(figures as reported by Anglican sources)*

### 2.3 WORKING TOGETHER with Partners (*Kenya*)

#### Comments from Partners

International agencies like Christian Aid and ActionAid are well aware of the work being done by ACK, and work with CAPA on HIV concerns. They believe that the church is a strong tool to overcome and mitigate the impact of HIV. A plus point according to these agencies was the potential of the church to address the issues of stigma, gender discrimination and justice, as well as its ability to deal with the psychosocial and spiritual aspects of HIV and AIDS. As the task ahead is huge and calls for a multi-sector response, the church is an invaluable partner with its own strengths and structure and capacity to mobilize communities.

During the research phase for this study, the Regional Coordinator of the Ecumenical HIV and AIDS Initiative in Africa said that the CAPA strategic plan could be owned by all and was designed in such a way that all members had a role to play - with the top leadership advocating and paving the way so that those at the parish and community level could be actively involved. In addition, the PEPFAR spokesperson was aware of ARV provision in Maseno and Muheza hospitals but did not know that these hospitals were Anglican. In a similar vein, PEPFAR was aware of the prevention programmes among youth in the coastal regions but did not know that Family Health International and APHIA were implementing work through the Anglican churches. The hope was expressed that PEPFAR would have a closer working relationship with the ACK in future.

#### Partners identified during this study include (with *some* of the work supported):

- ANARELA (advocacy)
- Care (VCT)
- Catholic Medical Mission Board (PMTCT)
- Catholic Relief Services (IEC, home-based care, hospitals)
- Christian Aid (advocacy)
- Christian Health Association of Kenya (PMTCT, hospitals, ARV)
- Ecumenical HIV& AIDS Initiative in Africa (IEC, advocacy)
- Family Health International (youth education, prevention education)
- Global Fund through AACC, Ministry of Health (home-based care, comprehensive care centres)
- International Centre for Reproductive Health
- Kingdom Children, Canada
- Ministry of Health (VCT, home-based care, IEC, PMTCT, ARV, hospitals)
- Mission for Essential Drugs (hospitals)
- NACC (IEP)
- NASCOP (IEC)
- National NGOs and CBOs (KANCO, NOPE, Social Impact, KAMATAKIMO) (IEC)
- Other church denominations
- PEPFAR (hospitals)
- Positive People's networks (e.g. Iko kitu, Jipe Moyo)
- Primate's World Relief and Development Fund (family dialogue, care and support)
- USAID (VCT, orphan care)
- World Council of Churches (IEC)
- World Relief (VCT, orphan care, peer educators)



*St Luke's Hospital, Kaloleni (Mombasa Diocese)*

## **TANZANIA – THE HEADLINES**

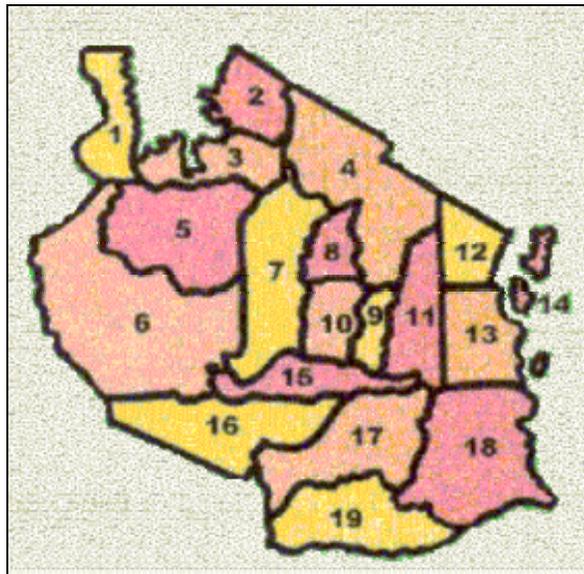
### **Key Features**

- **Extensive health service provision through 12 Anglican hospitals; Christian institutions provide most of hospital-based care in Tanzania**
- **10,000 PEOPLE given ARV treatment at 6 hospitals**
- **Programmes notable for their interfaith component, especially with Muslims**
- **Anglicans sub-recipients of Global Fund grants channelled via other Primary Recipients**
- **Huge mobilization of voluntary human and material resources through grassroots commitment, creativity and initiative: a lot is done with very little**
- **Significant existing networks of partnerships**

### **Key Lessons**

- **Excellent Anglican facilities for service delivery but the national level infrastructure (via CAPA) is a facilitating one; without a central, coordinated structure, the Anglican response may appear (to global institutions) to be disconnected and therefore difficult to engage with**
- **Anglican history and polity focuses energy and ownership at the diocesan level; Tanzania has proven to be a good example of this, in this study**
- **This raises pressing questions ‘if’ and ‘how’ energy and ownership of information, funding mechanisms, management, etc., can be more centralized in order to present a united front and access new partnerships and resources, without causing unease at diocesan level, or to existing partners**
- **Broad network of partnerships is vital in providing synergies, accountability, quality assurance**
- **Churches can make distinctive contributions on an interfaith basis**

## Chapter 3: Tanzania



### 3.1 THE ANGLICAN RESPONSE AT NATIONAL LEVEL

The Anglican Church of the Province of Tanzania (ACT) operates in all regions of Tanzania. ACT has a total of 21 dioceses with an estimated population of 1,540,366 baptized Anglicans. This is 5.3% of the total population and 21% of Tanzanian Christians.

The Anglican health system is extensive with 12 major hospitals almost all of which are involved with treatment, care and support. This is eye-catching and impressive. The response to this study shows that Tanzania seems to be a good example of something which is a feature of Anglican health ‘systems’ in that the central institutional structure at national level, through CAPA (which connects into the wider Anglican Communion and therefore the wider world) is a facilitating, enabling and communicating one, rather than a comprehensive management structure. It is currently slim, and has little spare capacity. This reflects Anglican polity in that energy and ownership, information and funding mechanisms are focused and managed primarily at the level of the diocese or of the specific health facility in question.

This raises two issues: first, there is a need to build institutional capacity; second, and more searching, there is something of a choice. The current model lends itself to existing

patterns of funding through historical partnerships, networks and coalitions; however, if Anglicans aspire to access some of the unprecedented levels of funding which are currently appearing, and for which FBOs are seen as likely recipients, then without a central, coordinated structure, the Anglican response may appear (to global institutions) to be disconnected and therefore difficult to engage with. This raises urgent questions about ‘if’ and ‘how’ energy and ownership of information, funding mechanisms, management etc. can (or should) be more centralized in order to present a united front and access new partnerships and resources, without causing unease at diocesan level, or to existing partners. The questions are urgent because other FBOs are doing this already, and because the window of opportunity may be limited.

### **3.1.1 The Response at National Level – Major Features**

- Prevention education: 14,600 youth reached through 182 youth peer educators.
- 17 Voluntary Counselling and Testing sites employing 34 trained counsellors.
- 6 sites offer Prevention of Mother to Child Transmission services.
- 10,000 persons provided with ARV in 6 ACT hospitals including CD4 facilities.
- 154 church volunteers provided bicycles for adherence follow up.
- 20,000 orphans and 3,000 affected widows are supported.
- 4,808 families reached through Home-Based Care.
- 28,000 Persons living with the virus are offered support by 240 paid workers and 750 volunteers.
- 125 persons are involved in advocacy efforts through Provincial office.
- The Mothers’ Union is a key (Anglican womens’) organization involved in implementation of programmes.
- Living With Hope programme (see text box).
- Global Fund (GFATM) grants as sub-recipients.

*(figures as reported by Anglican sources)*

#### **Living with Hope (Tanzania)**

The programme ‘Living with Hope’ was launched in November 2001 to address the challenges of the AIDS pandemic. The programme focuses on continuous improvement of health and social services provided by ACT Dioceses and Institutions. In addition to prompting some of the major responses reported above, some of the capacity-building features of this programme include:

- The Provincial HIV and AIDS office has been established and strengthened.
- Church leaders have been given counselling skills and knowledge to handle HIV issues and provide psychological support.
- ACT Dioceses have facilitated training for groups of women, youth and those living with HIV to disseminate HIV and AIDS messages to their families, peer groups and local communities.
- A strategic HIV and AIDS plan has been developed for the Province based on the ACT Vision and Mission Statement.

**Anglicans as Sub-recipients of Funds in  
Global Fund for AIDS, TB and Malaria Programme (*Tanzania*)**

This programme funded by the Global Fund works together with the Ministry of Health (MOH) in 45 districts. The Anglican Church in Tanzania (ACT) was one of the six sub-recipients of the Tanzania Christian Services Commission for Round 3 of a GFATM grant and was able to implement the programme in 5 hospital: Muheza, Iringa, Mbeya, Njombe and Korogwe. The aims of the programme were:

- To increase the access of the sexually active population (15-49 years) to VCT services in 45 target districts.
- To provide access to comprehensive care and support services to all persons living with the virus and TB patients in all 12 ACT hospitals and more than 35 health facilities.
- To increase the number of VCT centres and screening of HIV and TB .
- To increase the number of community care and supports groups which undertake community mobilization and sensitization, in order to increase acceptance of those living with HIV (and TB).
- To strengthen the capacity of ACT and partners to coordinate, monitor and evaluate the HIV and AIDS/TB and Malaria programmes.

**3.1.2 Programme Challenges at National Level**

There is a constant high drop out rate among workers in ACT hospitals. Stigma and discrimination still prevail, especially at family level. Nutrition support is not always adequate for those on ARV. Sustainability of programmes is a major challenge and donor policies and interest restrict funding. As the Global Fund could fund only 45 districts in Tanzania, ACT obtained funds for only 5 out of 21 dioceses.

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**3.2 ANGLICAN RESPONSES AT DIOCESAN LEVEL**

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**3.2.1 Diocese of Tanga**

The Diocese of Tanga occupies an area of 25,310 sq km and covers the whole of the Tanga Region and the south-eastern part of the Kilimanjaro Region. The diocese has 56 parish churches plus other smaller churches with over 100,000 Anglicans. The diocesan headquarters and cathedral are at Korogwe. The diocese is involved in the running of three hospitals: St, Raphael's, St.Francis, and Muheza hospital.

***The Response – Major Features***

- Prevention education: 25,100 congregation members and 600 youth reached.
- 300 mothers benefited from availed Prevention of Mother to Child Transmission services.
- Sexually transmitted infection control programme treated 400 persons.
- 30 trained counsellors in 8 testing sites have reached 6382 persons.
- 5,000 information, education and communication materials distributed mainly to youth.

- 2,200 persons provided antiretroviral therapy at Muheza hospital.
- 230 orphans supported, especially by Mothers' Union and youth.
- 100 families given Home-Based Care; each parish has people trained, including men.
- 50 paid persons and 210 volunteers work on the Diocesan AIDS programme.
- Funding generated within community and from individuals.
- Diocese undertakes advocacy work on access to treatment and rights of orphans and other vulnerable children.
- *'Diocesan Integrated AIDS Programme'* (see text box)  
(figures as reported by Anglican sources)

#### **Diocesan Integrated Aids Programme (*Tanzania, Tanga Diocese*)**

This programme helps those affected to generate income through agro-forestry, rearing livestock and poultry, fish ponds and bee-keeping. In Maramba, livestock such as dairy goats are provided for those living with the virus. The programme provides seeds on credit, tools and watering cans. The beneficiaries are those who are poor in the community including 200 persons living with HIV and 20 widows. They are further supported with medical care and transport facilities and through support groups. The programme is a way of overcoming stigma and discrimination.

#### ***Programme Challenges***

The diocese needs to expand its work to other deaneries especially to train persons for HBC and to provide bicycles for volunteers. It also hopes to have more camps for orphans and other vulnerable children. There are some 5000 orphans and it would be a challenge to reach out to all of them. The families looking after the children are themselves poor and often the support (food for example) given to the orphans is spread around the whole family. The Mothers' Union also hopes to have funds to begin income generating projects for widows, such as handicrafts, shamba and batik, as well as to be able to provide transport facilities for the women who do the home-based and orphan care.

#### **Muheza Hospital (*Tanzania, Tanga Diocese*)**

This 330-bed hospital is 126 years old and is the major hospital in the district providing ARV therapy. The hospital treats around 50,000 patients per year. An average of around 2,000 antenatal mothers benefit from PMTCT services per year of whom 10% are positive. 523 positive mothers have been treated so far. The hospital has 2,440 patients on ARV and all on first line regimen except a couple who are on second line. Initially the ARV programme was funded by the Diana Foundation and was meant only for the hospital staff many of whom were dying. In 2003 the programme was extended to others who were not staff. AIDS Relief and the Government now provide the ARV. The CD4 machine and technicians are funded by AIDS Relief. 21 staff are responsible for the programme. 5 others help follow up patients in the community and supervise the HBC. The hospital is located in a Muslim area and caters to more Muslims than Christians. The World Food Program helps patients with their nutritional needs. The hospital reports to the MOH and AIDS Relief.

**Linking their Faith to Community Needs - The Old Korogwe VCT  
(Tanzania, Tanga Diocese)**

The old Korogwe VCT is located on the side of the main road leading out of town. It is unique as it is manned entirely by youth, except for one paid counsellor from the Diocese. Young people from the nearby town are trained as peer educators. There are 25 of them, of whom 9 have completed school. They work among the community, motivating and encouraging people to opt for VCT and helping to bring them to the centre. Trained as HBC providers, they visit homes to educate families, especially on nutritional support and also help in procuring medicines. HBC kits supplied by the MOH and funded by the Global Fund are provided by the centre. When they visit families they not only provide HBC but also encourage them by praying with them, singing songs and doing odd jobs for them. A challenge they face is the lack of transport to take ill patients to hospital. Each of them visits about 10 homes every weekend. They are encouraged in their work by the fact that they see visible changes in the community with less stigma and discrimination, especially when people are educated on modes of transmission. They have noticed that those who are positive are also openly declaring their status. The youth help link patients and families to religious leaders in the community as they know this supports families emotionally. Both Christian and Muslim youth are part of the group and they inform the faith leaders of the families who need support.



*Palliative Care at Muheza Hospital (Tanga Diocese)*

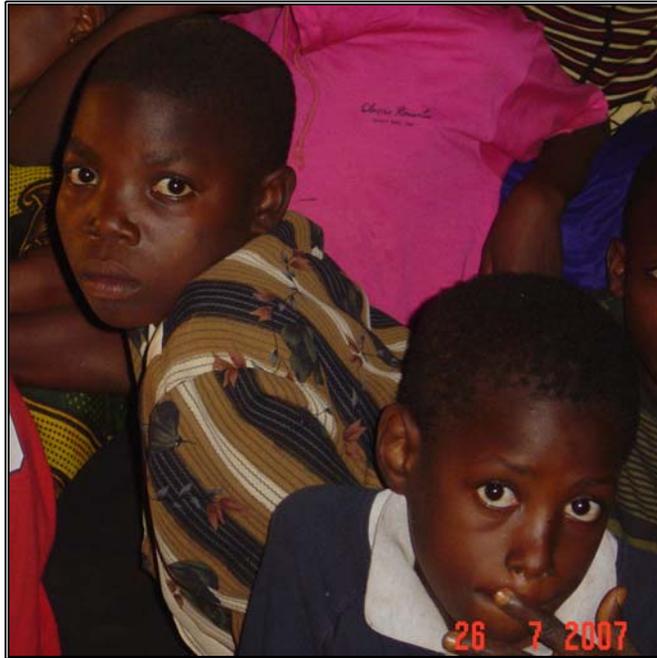
### **3.3 WORKING TOGETHER with Partners (Tanzania)**

#### **Comments from Partners**

The Global Fund supports ACT work via other partners. During the research for this study, the Director of the Christian Social Services Commission at the GFATM office said that the Anglican churches and institutions are doing a great job but are 'hiding their light under a bushel'. The churches have a great advantage over other organizations, considering the fact that they have existed for a long time and are good at working with others. One of the drawbacks of the churches is the lack of human resources and capacity to absorb funds. One of the suggestions given was that churches should technically document their programmes and projects so that others could learn from them.

#### **Partners identified during this study include (with *some* of the work supported):**

- ActionAid (home-based care)
- AIDS Relief (hospitals)
- AMREF (VCT)
- Christian Aid (prevention education, home-based care)
- Compassion International (advocacy)
- EED (orphan care)
- Global Fund via Tanzania Christian Services Commission (VCT)
- Health Serve Australia (orphan care)
- Jubilee Ministries (home-based care)
- Ministry of Health (VCT, hospitals, home-based care)
- Médecins sans Frontières (hospitals)
- Positive persons networks SHIDEPHA, TANERALA (home-based care, advocacy)
- Primate's World Relief and Development Fund (prevention education, orphan care)
- PSI (home-based care)
- TACAIDS (hospitals, home-based care)
- Xavier Foundation
- World Vision



*Orphan Care (Tanga Diocese)*

## ZAMBIA – THE HEADLINES

### Key Features

- **Anglicans work as part of the Churches Health Association of Zambia (CHAZ), which provides an umbrella coalition and a strong working relationship, although there is only one Anglican hospital which directly benefits**
- **Anglicans have received Global Fund grants as sub-recipients, with funds channelled through CHAZ**
- **30,000 condoms have been distributed in 2 dioceses**
- **Distinctive strengths in Care and Support, including outstanding Home-Based care**
- **Strong presence of Mothers' Union and delivery of services by women**

### Key lessons

- **Relationship with CHAZ and others emphasizes importance of existing networks and partnerships in strengthening Anglican delivery, accountability and effectiveness**
- **A direct approach by Anglicans (e.g. to Global Fund) would touch on some sensitivities; it would be necessary to explore what flexibility there is within existing networks so as to maximize Anglican initiatives and build Anglican capacity**
- **Anglican pragmatism is illustrated by the impressive programme of condom distribution**
- **Strong Care and Support programme could be scaled up, resources permitting, replicating best case practice**
- **Women volunteers demonstrate that churches do a lot with a little but: “give us a bicycle and we’ll do even more”!**
- **Anglican programmes confirm ARHAP study findings concerning nature, inspiration, comparative advantages and considerable extent of faith-based health service delivery**

## Chapter 4: Zambia

*... insert map of Zambia with dioceses and projects focused on*

### 4.1 THE ANGLICAN RESPONSE AT NATIONAL LEVEL

Zambia, along with Botswana, Zimbabwe and Malawi, is part of the Anglican Province of Central Africa. Each of these countries is led by a Bishop and has its own community development work including HIV and AIDS Programmes. The headquarters of the province is located in Malawi which also is the seat of the Archbishop. The province has been actively involved in HIV prevention since 2001. In Zambia, there are 5 Anglican dioceses within the Zambian Anglican Council (ZAC).

The nature of the faith-based response in Zambia, together with some data about its extent, has already been produced in the form of the ARHAP study<sup>1</sup> (see text box). Anglicans are a part of this picture.

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<sup>1</sup> African Religious Health Assets Programme, “Appreciating Assets: The Contribution of Religion to Universal Access in Africa”, report for the WHO (Cape Town: ARHAP, Oct 2006)

### **ARHAP and Anglicans (*Zambia*)**

The African Religious Health Assets Program (ARHAP) under contract to The World Health Organization (WHO) in 2006 published a report on the Contribution of Religion to Universal Access in Africa. The study undertaken in Zambia and Lesotho recognizes the immense contributions of religious groups and faith-based organizations and suggests that they could be more effectively mobilized and linked for scale up to universal access. Many have been identified as “exemplars” by their peers and have “promising practices” to share and build upon. Religious entities have strong local commitment and are perceived as contributing to health, wellbeing and the response to HIV through tangible and intangible means. The report acknowledges that it is this combination that distinguishes them and gives them strength. Leading tangible factors comprise compassionate care, material support and health provision; leading intangibles are spiritual encouragement, knowledge giving and moral formation.

The ARHAP report states that Anglicans along with other mainstream Protestants account for 27% of Religious Health Assets in Zambia and (for example) the Anglican Diocese of Northern Zambia is mentioned in the report as one of the linking bodies enabling the faith-based response to HIV and AIDS. Anglicans comprise some 5% of the respondents surveyed by ARHAP, and 3 Anglican congregations have been mapped, 2 in the Copperbelt and one in the Eastern region. The ARHAP study suggests that Anglicans are especially involved in Care and Support in Zambia, and also (but to a lesser extent) in treatment. This echoes the findings of our own study, which also confirms the ARHAP comments concerning the nature, inspiration, comparative advantages and considerable extent of faith-based health service delivery in Zambia, as in other parts of Africa.

#### **3.1.1 *The Response at National Level – Major Features***

- 32 people work at national level, of whom 10 are paid, including two people living with the virus.
- A national committee provides leadership and guidance and there is a National Programme Coordinator.
- Care and Support is the main activity in all dioceses.
- 3,418 out of school youth trained as peer counsellors.
- 3,526 congregation members trained in outreach.
- 300 antenatal mothers offered Prevention of Mother to Child Transmission.
- 547 persons offered Voluntary Counselling and Testing in one year at 4 sites.
- 2,000 pamphlets and 500 posters distributed to churches.
- 317 persons living with HIV provided with antiretroviral therapy at medical centres.
- 3,220 orphans offered care under programme with 16 paid staff and 43 volunteers, involving Mothers’ Union and clergy wives.
- 640 persons living with the virus provided with support through Drop-in Centre.
- 312 families given Home-Based Care under programme with 7 paid staff and 200 volunteers.

- Advocacy efforts by ZAC directed towards: stigma, discrimination, orphans and other vulnerable children, access to treatment, food security and legal rights of those living with HIV. There are 10 staff working on advocacy (two of them paid).

*(figures as reported by Anglican sources)*

#### **Lusaka Diocese (*Zambia*)**

Lusaka Diocese is involved in HIV and AIDS education and prevention, stigma reduction, and works with support groups and networks. The Bishop of the Diocese is the Chairman of ZAC and ANARELA. They have mobile testing services and promote behavioural change in communities. "Circle of Hope" is a group of persons living with the virus led by the Bishop to sensitize the communities and church members. There is youth empowerment and home-based care for the chronically ill and elderly, and Directly Observed Therapy (DOT) and ARV adherence follow up. The church cathedral in Lusaka is soon to begin a Voluntary Counselling and Testing centre on its premises.

#### **Eastern Diocese (*Zambia*)**

The Eastern Diocese has its focus on food security, and has a Comprehensive Care Centre at St. Francis Hospital which is the only Anglican hospital in Zambia providing ARV. The hospital works in close collaboration with the Government in getting supplies.

## **4.2 ANGLICAN RESPONSES AT DIOCESAN LEVEL**

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### **4.2.1 Northern Zambia Diocese**

This diocese is located in the Copperbelt and covers Kitwe, Kalulushi, Mufurira, Jinkola Champishi, Chirilabombwe, Mwunilunga, Sowezi, Kabongo, Zambezi and Chavuma. The diocese has 16 parishes and 5,000 parishioners with women and youth constituting the majority. There are 20 active serving clergy.

#### ***The Response – Major Features***

- Home-Based Care is a major feature of the response in this diocese.
- 125 women and men were trained as home-based care volunteers by the Ministry of Health; women and men travel as far as 5 km to provide holistic HBC.
- 20 peer educators trained by Ministry of Health to provide counselling to young people and 6 counselling facilitators as trainers.
- Drug adherence counselling given especially to those on ARV and DOT therapy.
- Nutritional supplements provided to severely ill clients.
- Stigma reduction and education at family level.
- Assistance to terminally ill patients to the hospital or clinic using their bicycle.
- Reach out is regardless of faith or denomination.
- Micro Credit Scheme: 40 men and women trained in micro-entrepreneurship and development and given loans.

- Youth (who are orphans due to HIV) given training in tailoring and brick making  
(figures as reported by Anglican sources)

### ***Programme Challenges***

Despite the success recorded, the diocese still encounters some challenges such as lack of cooperation from clients due to stigma and fear, burn out on the part of the caregivers due to an increasing number of households to visit yet few HBC workers, lack of tools for sanitation, and excessive expectations of clients in terms of the provision of medication and nutritional supplements. The caregivers work on volunteer basis and include those who are themselves widows and widowers.

### ***4.2.2 Diocese of Central Zambia***

This diocese covers the entire national central province of the country and part of Copperbelt. It has 20 active priests serving about 20,000 church members.

### ***The Response – Major Features***

- 2 paid staff and 20 volunteers, including people living with the virus.
- Emphasis on home-based care, orphans and vulnerable children and prevention education.
- 20,000 condoms distributed, working with Government.
- 250 youth reached by prevention education and 750 congregation members STI control programme reaching out to 100 clients.
- 240 persons offered VCT in one centre.
- 1,000 orphans supported, and 300 affected widows supported by 29 volunteers.
- 120 volunteers provide HBC in collaboration with the Government.
- One hospital (but not with ARV).
- Income generation through poultry farming, dairy cattle, raising crops.
- Advocacy programmes in partnership with other church denominations.
- Clergy talk about AIDS prevention from the pulpit, encouraging couples to seek medical counselling and to use condoms; they encourage youth on abstinence.
- The Bishop provides leadership by participating in national discussions to help reduce the spread of HIV and reduce stigma and discrimination.

### ***Margaret Home, Ndolo (Zambia, Central Diocese)***

'Margaret Home' is a community project located in Ndolo. This is a five year old skills acquisition centre where women are trained in tailoring skills. 56 of the 156 women trained are now gainfully employed in the private sector. The students, trained in accordance with Zambian vocational standards, are able to generate income and sustain their families mainly through employment in the textile and clothing industries. This centre is an initiative of the Mothers' Union and is administered by them. It provides support to affected widows, poor women, and out of school young women. This helps reduce their vulnerability to HIV and the likelihood of having to turn to sex work. The centre has 3 staff tutors and receives some funding from the diocese to sponsor those who cannot afford the token fees. HIV and health education is integrated into the training curriculum of the tailoring centre. Key challenges include inadequate funds to pay the tutors, to procure sewing machines and to enrol more women.

**Mission Redeemer Charity Project, Luwasha (*Zambia, Central Diocese*)**

St. George's Anglican Church is located in Luwasha town of the Central Diocese of Zambia. A group of elderly volunteers who are members of the Church have formed an organization called "Mission Redeemer Charity Project". The group includes both men and women from different disciplines (educators, nurses and counsellors). It seeks to empower men and women bereaved by the AIDS epidemic with basic skills such as tie and dye, tailoring, poultry raising and other income generating activities that will bring about self development and sustenance. The group meets twice a month at the church compound for their regular meetings, where they discuss issues that affect the group and plan ways of overcoming them.

They also give health and HIV education and psycho-social counselling to those living with and affected by the virus in communities around Luwasha, as well as education on basic health issues with the help of the nurses who are their members.

The group has formed a Day Care Centre at St. George's Anglican Church where children from different communities around Luwasha come for education and nutrition. The group cares for 70 to 100 children between 3 -15 years, 60% of them girls, who have lost one or both of their parents. The children come from different faith, ethnic and denominational backgrounds.

Clothing and footwear are donated by the church and community members and distributed to children and their families. The group is strongly supported by St. George's Church in a number of ways, including with cash and material donations. The church provides a big hall where the children and women meet for learning, sharing and recreation. There are special prayers said for the women and children, funds are raised during special Sundays and Lent, and spiritual counselling is provided by the parish priests. The Church has demonstrated its commitment to the children by donating considerable land located within its compound for the group to build classrooms for them. Some of the challenges faced by these children and women include the lack of appropriate classrooms, a shortage of learning materials such as note and textbooks, no school uniforms and footwear, as well as an inability to respond to every medical need. The group at times gets financial support from the Government of Zambia through the development fund of Luwasha constituency.

#### **4.2.3 Diocese of Luapula**

##### ***The Response – Major Features***

- 4 paid staff and 127 volunteers, including those living with HIV.
- 7,100 youth reached through the abstinence approach (AB).
- Another 6,500 youth reached in locations where condoms are also advocated where 10,000 condoms (supplied by Youth Alive) have been distributed.
- 12,000 congregation members sensitized.
- Educational work in support of 1,200 sex workers.
- Anglican hospitals and health centres have treated 720 people for STI control, and around 400 women have benefited from PMTCT services.
- Diocese does not have testing sites but has 22 trained counsellors who have counselled around 2,000 persons for VCT in the churches and community.

- 1,200 IEC materials supplied by CHAZ have been distributed in the last year to youth and pregnant mothers.
- Diocesan medical centres have provided ARV treatment to 147 patients.
- 44 volunteers help support 735 orphans by providing them with education, medical aid, transport, clothing, nutrition, day care and institutional care.
- 150 infected and affected widows are provided with institutional care by 20 volunteers.
- Volunteers living with the virus provide HBC to 197 families.
- Training, advocacy and work on stigma and discrimination are undertaken by the diocese in partnership with other churches, NGOs, positive persons, networks (such as CHAZ, ZAMBART). 12 persons work on advocacy efforts as volunteers.

*(figures as reported by Anglican sources)*

### **4.3 WORKING TOGETHER with Partners (Zambia)**

#### **Comments from Partners**

This study found out that UNAIDS in Zambia is not involved in direct partnership with the Anglican churches; the reason given was that direct involvement with the church is technically difficult. UNAIDS was keen that the Anglican Church identify entry points with the existing UNAIDS activities, Zambia AIDS control and inter- and intra-religious organizations. USAID, operating through PEPFAR, suggested that the church should mainstream activities with the Government as the present institutional capacity of the church may make it difficult to access direct funds from PEPFAR or become sub-recipients of the existing primary partners.

#### **Partners identified during this study include** (with *some* of the work supported):

DHMTS (medical centres, IEC)  
Ministry of Health (training, prevention education, medical centres)  
CHAZ (all aspects)  
ZANAN (IEC)  
Episcopal Relief and Development (PMTCT, VCT)  
CMS (PMTCT, VCT, prevention education)  
Global Fund via CHAZ, National HIV/AIDS Council Zambia (NAC)  
Family Health International  
Positive persons networks (advocacy)  
WCC (training, advocacy)  
ZAMBART (advocacy, training)



*Care and Support Volunteers, women and men (Zambia)*

## **Appendix 1: The Anglican Response in the Rest of Africa**

The time and resources available for this study mean that its scope has been limited to Africa, and within that continent we were asked to focus in on three countries: Kenya, Tanzania and Zambia. This is not to neglect the rest of the continent, nor the rest of the Anglican Communion across the world, but because it is better to look more closely at a limited sample, than superficially at everything. Lessons learnt in this study are intended to benefit the whole Communion, and in the first instance it is hoped that this work will inform the agenda being led by CAPA, and bring that to the attention of the wider Anglican family.

The countries studied were chosen not by the Anglican Church, but by WHO and UNAIDS, and as such they provide a fascinating sample which draws out some of the many strengths of the Anglican response, as well as lessons to be learnt.

A picture of the wider Anglican response throughout Africa can be gleaned from the CAPA Desk Review<sup>1</sup> (Feb, 2007) in which various Anglican provinces (each covering one or more countries) give an account of ‘Programme Achievements.’ The achievements are those which can be attributed specifically to the Anglican *institutional* structures in each province, under the CAPA umbrella. Sometimes that institutional structure is in its infancy and the programme achievements reflect that. This does not mean however, that there is no Anglican work going on. As already noted, a good deal of work is done at grassroots level through local structures and in partnership with many organizations.

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<sup>1</sup> <http://hivaids.anglicancommunion.org/resources/docs/CAPA%20Desk%20Review%202001-2005.pdf>

## Appendix 2: Methodology

The countries which this report focuses on were chosen by WHO and UNAIDS. That allows this study to look at an independently chosen sample and makes it into an honest assessment, rather than a sales exercise on behalf of the Communion.

A huge amount is done by Anglicans, but the extent of it has never been definitively mapped. To do so – to produce a detailed mapping of the entire Anglican engagement in HIV and AIDS interventions in Africa - would need considerable input in terms of time, manpower and funds. Therefore it was decided that a pilot survey would be carried out to give a taste of the work being done through Anglican structures in three countries - Kenya, Zambia and Tanzania - with a detailed focus on up to three dioceses or study sites in each country.

Existing data on Anglican engagement in Africa such as the CAPA Desk Review (Feb, 2007) and other published documents, as well as material from the internet, have been reviewed. A questionnaire was formulated and distributed to the chosen dioceses and the national coordinators. The questionnaire covered details of interventions in prevention, treatment, care and support and advocacy such as number of programs, numbers targeted, funds available, numbers of paid workers and volunteers, partnerships, suppliers, church policy etc. Respondents were given 15 days to reply.

Data from each diocese has been compiled under each country chapter. Figures shown are *as reported* from Anglican sources. Every reasonable effort has been made within the scope of this study to verify them. The responses to the study were somewhat uneven, from country to country and between dioceses/study sites. In consequence, the reporting here is not perfectly balanced in terms of detail and type of data.

The response to the questionnaire was revealing. In general terms, it was very high (although this was to be expected since it was not a random survey, but a document sent with the authority of CAPA to a limited number of specific post-holders). Closer scrutiny suggests that there were certain areas which respondents did not feel it appropriate to supply details of: sources of funding for example. This fact, which seemed initially to be a puzzling discrepancy, actually turns out to be helpful in understanding Anglican structures. It highlights the nature of Anglican polity and how Anglican energy and structures for responding to HIV and AIDS are focussed at the diocesan level. This in turn raises interesting questions about building the Anglican institutional capacity, which are dealt with in the report.

Objectivity was brought to the study through the work of an independent consultant, Dr Sheila Bharathan. The Consultant, along with the CAPA HIV and AIDS Coordinator, Emmanuel Olatunji, and accompanied by the national coordinator, undertook a field visit of three days in each country with the objectives of verifying data and accuracy of reporting, of having an on site knowledge of projects which could be highlighted as best practice models, and of meeting with international and partner agencies for the

triangulation of data. The findings were compiled by the Consultant with input and feedback from others in the team.

A 'Consultant's Report' was submitted to AUNO Geneva and the contents passed back to national coordinators to cross-check data and to give them the opportunity to correct matters of perception. Finally, AUNO Geneva prepared the final report for submission to UNAIDS and WHO.

### **Appendix 3: Anglican & Ecumenical Offices/Organizations**

#### **The Council of Anglican Provinces of Africa (CAPA)**

Emmanuel Olatunji  
HIV and AIDS/Malaria/TB Coordinator  
Kilimani, Komo Lane, Off Wood Avenue  
P.O. Box 10329 - 00100 G.P.O  
Nairobi  
Kenya  
Tel: +254 20 387 3700, Fax: +254 20 387 0876  
Email: [info@capa-hq.org](mailto:info@capa-hq.org), [olatunji@capa-hq.org](mailto:olatunji@capa-hq.org)  
Website: <http://hivaids.anglicancommunion.org/>

#### **Anglican UN Office (AUNO) Geneva**

Revd. Michael French  
Centre Oecuménique  
150 Route de Ferney , CH-1211 Geneva 2  
Switzerland  
Tel: +41 22 791 6556  
Email: [aunogeneva@anglicancommunion.org](mailto:aunogeneva@anglicancommunion.org)  
(direct line: +41 22 779 0465, direct e-mail: [m.french@anglican.ch](mailto:m.french@anglican.ch))  
Website: [www.anglicancommunion.org/un/geneva.htm](http://www.anglicancommunion.org/un/geneva.htm)

#### **Anglican Observer at the UN**

Ms. Hellen Grace Wangusa  
Anglican Observer at the United Nations  
Anglican Communion Office at the United Nations  
815 Second Avenue, New York, NY 10017  
USA  
Tel: +1 212 716 6263, Fax: +1 212 687 1336  
Email: [unoffice@episcopalchurch.org](mailto:unoffice@episcopalchurch.org)  
Website: [www.anglicancommunion.org/un/](http://www.anglicancommunion.org/un/)

#### **Anglican Communion Office**

The Revd Canon Kenneth Kearon  
Secretary General of the Anglican Communion  
St Andrew's House, 16 Tavistock Crescent  
London, W11 1AP  
United Kingdom  
Tel +44 20 7313 3900, Fax +44 20 7313 3999  
Website: [www.anglicancommunion.org/](http://www.anglicancommunion.org/)

**Archbishop of Canterbury's Secretary for International Development**

Revd. David Peck  
Lambeth Palace  
London, SE1 7JU  
United Kingdom  
Telephone: + 44 20 7898 1242 Fax: +44 20 7401 9886  
E mail: david.peck@lambethpalace.org.uk, david.peck@c-of-e.org.uk  
Website: <http://aid.anglicancommunion.org/>

**Anglican Church of Kenya (ACK)**

Mr. Joseph N. Wangai  
National CAPA Co-ordinator, Kenya  
P.O. Box 40502, Nairobi  
Kenya  
Tel Office +254-2-714755, Fax. +254 2 718442  
Email: ackdev@africonline.co.ke; jwangai2005@yahoo.com  
Website: [www.ackkenya.org](http://www.ackkenya.org)

**Anglican Church of Tanzania (ACT)**

National CAPA Co-ordinator, Tanzania  
Mrs. Neema Peter Majule  
The Anglican Church of Tanzania  
P.O. Box 899, Dodoma  
Tanzania  
Tel : +255 26 232 1437, 232 1860, Fax : +255 26 232 4565  
Email: [neema@anglican.or.tz](mailto:neema@anglican.or.tz)  
Website: [www.anglican.or.tz](http://www.anglican.or.tz)

**Zambian Anglican Council (ZAC)**

National CAPA Co-ordinator  
Dr. Pelham Hazeley (acting)  
Email: [pjpelham@hotmail.com](mailto:pjpelham@hotmail.com)

**All Africa Conference of Churches**

General Secretariat  
P.O. Box 14205 - 00800 Westlands,  
Nairobi  
Kenya  
Tel: +254 20 4441483/4441338/9, Fax: +254 20 4443241/4445835  
Email: [christine@aacc-ceta.org](mailto:christine@aacc-ceta.org) (web editor)  
Website: [www.aacc-ceta.org](http://www.aacc-ceta.org)

**World Council of Churches**

Rev. Dr. Samuel Kobia  
General Secretary  
150 route de Ferney, P.O. Box 2100  
1211 Geneva 2,  
Switzerland  
Tel.: +41 22 791 6111, Fax: +41 22 791 0361  
Website: [www.wcc-coe.org](http://www.wcc-coe.org)

**Christian Aid (London Office)**

35 Lower Marsh  
London  
SE1 7RL  
United Kingdom  
Tel: +44 20 7523 2321/2105  
Email: [london@christian-aid.org](mailto:london@christian-aid.org)  
Website: [www.christian-aid.org](http://www.christian-aid.org)

**Christian Health Association of Kenya**

P.O. Box 30690  
GPO 00100 Nairobi  
Kenya  
Tel: +254 2 4441920, or 4445160, Fax: +254 2 4440306  
Email: [secretariat@chak.or.ke](mailto:secretariat@chak.or.ke)  
Website: <http://www.chak.or.ke/>

**Churches Health Association of Zambia**

Ben Bella Road, Plot 9306  
P.O Box 34511, Lusaka  
Zambia  
Tel: +260 1 229702/237328, Fax: +260 1 223297  
Website: [http://www.zamcart.co.zm/new\\_chaz/index.php](http://www.zamcart.co.zm/new_chaz/index.php)

**Ecumenical HIV& AIDS Initiative in Africa**

Rev. Dr Nyambura Njoroge  
Project Coordinator  
World Council of Churches, P.O. Box 2100  
1211 Geneva 2, Switzerland  
Tel: +41 22 791 6111  
Email: [nn@wcc-coe.org](mailto:nn@wcc-coe.org)

**Episcopal Relief and Development**

815 Second Ave New York City,  
NY 10017, U.S.A.  
Tel: +1 800 334-7626 ext. 5129  
Email: [program@er-d.org](mailto:program@er-d.org)  
Website: [www.er-d.org](http://www.er-d.org)

**Mothers' Union**

Mr Reg Bailey  
Chief Executive  
Mothers' Union, Mary Sumner House  
24 Tufton Street  
London, SW1P 3RB  
United Kingdom  
Tel: +44 20 7222 5533, Fax: +44 20 7222 1591  
Email: [reg.bailey@themothersunion.org](mailto:reg.bailey@themothersunion.org)  
Website: [www.themothersunion.org](http://www.themothersunion.org)

**Primate's World Relief and Development Fund (Anglican Church of Canada)**

80 Hayden Street Toronto  
Ontario M4Y 3G2  
Canada  
Tel: +1 416 924 9192, Fax: +1 416-924-3483  
E-mail: [pwrdf@pwrdf.org](mailto:pwrdf@pwrdf.org)  
Website: [www.pwrdf.org](http://www.pwrdf.org)

## Appendix 4: Acronyms and Glossary

*See also text box (p.9) for explanation of Anglican terms*

<b>Anglican</b>	part of the worldwide Anglican community with historical origins in the Church of England, now spread around the world
<b>Archbishop</b>	Senior ordained person responsible for a province (see Primate)
<b>Bishop</b>	Senior ordained person with leadership responsibilities for his/her diocese and as part of national/provincial Anglican leadership. Some provinces have women as bishops, some do not
<b>Communion</b>	The worldwide Anglican community. Each member church (e.g. Church of England, Anglican Church of Kenya) is a part of the Communion)
<b>Congregation</b>	A local Anglican community which gathers to express its faith and worship. A parish may have one or more congregations in it.
<b>Diocese</b>	A subdivision of the province. A diocese may correspond roughly to a political district, although may sometimes be far more extensive depending on the number of Anglicans in it. The diocese is one of the fundamental units of church administration and governance. Each diocese is led by a bishop
<b>Episcopal</b>	(literally: ‘of bishops’, referring to a system of church governance based on the leadership of bishops). Term used to refer to the Anglican Church in certain parts of the world – sometimes the two are used together to embrace all usages, i.e. ‘Anglican-Episcopal’
<b>Lay</b>	Not ordained
<b>Minister</b>	Term sometimes used to refer to the local ordained leader in a parish or congregation (other terms: priest, vicar, rector, curate)
<b>Ordained</b>	Used of a church leader authorized to perform certain elements of leadership of worship and in the church community
<b>Parish</b>	Individual churches - also known as parishes - are subdivisions of the diocese. They may cover a neighbourhood, village or several communities and are in effect deeply-rooted Community-Based Organizations (CBOs).
<b>Priest</b>	Ordained leader who at the local level may be responsible for the worship and life of a parish or congregation
<b>Primate</b>	Senior ordained person responsible for a province (see Archbishop)
<b>Province</b>	Each member Church is referred to as a Province, of the Anglican Communion, and is governed independently, led by an Archbishop or ‘Primate’. Provinces usually correspond to national boundaries, though sometimes cover more than one country. Not to be confused with a political/administrative unit within a country (e.g. Western Province of Kenya)

<b>AACC</b>	All Africa Conference of Churches
<b>AB</b>	Abstinence-Be Faithful
<b>ABY</b>	Abstinence-Be Faithful for Youth
<b>ACK</b>	Anglican Church of Kenya
<b>ACT</b>	Anglican Church of Tanzania
<b>AIDS</b>	Acquired Immuno-Deficiency Syndrome
<b>AMREF</b>	African Medical and Research Foundation
<b>ANARELA</b>	African network of Religious Leaders Living with and Affected by HIV & AIDS
<b>APHIA</b>	AIDS, Population, and Health Integrated Assistance Program
<b>ARHAP</b>	African Religious Health Assets Program
<b>ARV</b>	Antiretroviral (Therapy)
<b>AUNO</b>	Anglican United Nations Office
<b>CAPA</b>	Council of Anglican Provinces of Africa
<b>CBO</b>	Community-Based Organization
<b>CCS</b>	Christian Community Services
<b>CCC</b>	Comprehensive Care Centre
<b>CCHIA</b>	Coast Churches HIV and AIDS Initiative
<b>CD4</b>	CD4 Cells ('clusters of differentiation', also known as T-Cells) help the body prevent infection. HIV attacks CD4 cells.
<b>CHAK</b>	Christian Health Association of Kenya
<b>CHAZ</b>	Churches Health Association of Zambia
<b>CMMB</b>	Catholic Medical Mission Board
<b>CMS</b>	Church Mission Society
<b>CRS</b>	Catholic Relief Services
<b>DOT</b>	Directly Observed Therapy
<b>DSS</b>	Department of Social Services
<b>EED</b>	Evangelischer Entwicklungsdienst (Germany)
<b>EHAIA</b>	Ecumenical HIV&AIDS Initiative in Africa
<b>ERD</b>	Episcopal Relief and Development
<b>FAQs</b>	Frequently-Asked Questions
<b>FBO</b>	Faith-Based Organization
<b>FHI</b>	Family Health International
<b>GFATM</b>	Global Fund for AIDS, Tuberculosis & Malaria (also referred to as the <b>Global Fund</b> )
<b>HBC</b>	Home-Based Care
<b>HIV</b>	Human immunodeficiency virus
<b>ICRH</b>	International Centre for Reproductive Health
<b>IEC</b>	Information, Education, Communication
<b>IGAs</b>	Income Generating Activities
<b>KAMA</b>	Kenya Anglican Men's Association
<b>KANCO</b>	Kenya AIDS NGOs Consortium
<b>M &amp; E</b>	Monitoring and Evaluation
<b>MOH</b>	Ministry of Health
<b>MSF</b>	Médecins Sans Frontières

<b>NAC</b>	National HIV/AIDS Council (Zambia)
<b>NASCOP</b>	National HIV/AIDS and STD Control Program of Kenya
<b>NGO</b>	Non-Governmental Organization
<b>OVC</b>	Orphans and other Vulnerable Children
<b>PEPFAR</b>	President's Emergency Plan For AIDS Relief
<b>PMTCT</b>	Prevention of Mother to Child Transmission
<b>PWRDF</b>	Primate's World Relief and Development Fund (Canada)
<b>SHIDEPHA</b>	Service Health and Development for People Living with HIV and AIDS
<b>STI</b>	Sexually Transmitted Infection
<b>TACAIDS</b>	Tanzania Commission for AIDS
<b>TB</b>	Tuberculosis
<b>TEAM</b>	Towards Effective Anglican Mission (conference)
<b>WHO</b>	World Health Organization
<b>VCT</b>	Voluntary Counselling and Testing
<b>UN</b>	United Nations
<b>UNAIDS</b>	Joint United Nations programme on HIV&AIDS
<b>UNICEF</b>	United Nations Children's Fund
<b>USAID</b>	United States Agency for International Development
<b>WCC</b>	World Council of Churches
<b>ZAC</b>	Zambian Anglican Council
<b>ZAMBART</b>	Zambian AIDS-related Tuberculosis Project
<b>ZNAN</b>	Zambia National AIDS Network

## **Appendix 5: Bibliography and Resources**

### **Anglican Communion News Service**

[www.anglicancommunion.org/acns/](http://www.anglicancommunion.org/acns/)

### **ARHAP**

African Religious Health Assets Programme, “Appreciating Assets: The Contribution of Religion to Universal Access in Africa”, report for the WHO (Cape Town: ARHAP, Oct 2006)

<http://www.arhap.uct.ac.za/publications.php>

### **CAPA HIV&AIDS Programme (HIV&AIDS, TB and Malaria)**

<http://hivaids.anglicancommunion.org/about/index.cfm>

### **CAPA Desk Review (2007)**

<http://hivaids.anglicancommunion.org/resources/docs/CAPA%20Desk%20Review%20001-2005.pdf>

### **CAPA Strategic Plan (2007)**

<http://hivaids.anglicancommunion.org/resources/docs/CAPA%20Strategic%20Plan%202007-2011.pdf>

### **WCC**

Declarations and policy statements on HIV&AIDS by churches and faith-based organizations from 2001 to 2005

<http://www.wcc-coe.org/wcc/what/mission/hiv-aids-statements01-05.html>

[www.oikoumene.org/en/resources/documents/other-ecumenical-bodies/church-statements-on-hivaids/anglican-provinces-in-africa.html](http://www.oikoumene.org/en/resources/documents/other-ecumenical-bodies/church-statements-on-hivaids/anglican-provinces-in-africa.html)

### **World Vision/Christian Connections for International Health/Friends of the Global Fight**

‘Engaging with the Global Fund to Fight AIDS, Tuberculosis and Malaria: A Primer for Faith-Based Organizations’,

[http://www.theglobalfund.org/en/files/partners/friends/Manual\\_Final.pdf](http://www.theglobalfund.org/en/files/partners/friends/Manual_Final.pdf)

### **TEAM Conference (Boksburg, 2007)**

[www.team2007.org](http://www.team2007.org)